104TH CONGRESS
2D SESSION

S. 1926

To provide for the integrity of the Medicare program under title XVIII of the Social Security Act, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 28, 1996

Mr. COCHRAN (for himself and Mr. SPECTER) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for the integrity of the Medicare program under title XVIII of the Social Security Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 11001. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO OBRA; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Emergency Medicare Protection Act of 1996''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment

to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO OBRA.—In this Act, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1989'', ''OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—MEDICARE SAVINGS

Subtitle A—Provisions Relating to Part A

SEC. 11101. UPDATES FOR PPS HOSPITALS.

(a) UPDATE FACTORS.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking subclauses (XII) and (XIII) and inserting the following:

''(XII) for each of the fiscal years 1997 through 2002, the market basket percentage increase minus 1.5 percentage points for hospitals in all areas, and

''(XIII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

(b) ADJUSTMENTS FOR CASE MIX WHEN RECALIBRATING DRGS.—

(1) IN GENERAL.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended by adding at the end the following:

''(F) ADJUSTING FOR ESTIMATED CHANGE IN CASE MIX.—

''(i) IN GENERAL.—Effective for discharges occurring in a fiscal year in which the Secretary implements significant changes (as defined by the Secretary) in the diagnosis-related group classification system and thereafter, the Secretary may (subject to clause (ii)) adjust the standardized amounts to take into account estimated case mix increase not attributable to real case mix increase anticipated to occur during the fiscal year to which the standardized amounts apply.

''(ii) REFINEMENT.—With regard to the adjustment described in clause (i), if the Secretary determines, based on data taken from the fiscal year to which the adjustment applied, that the amount of the adjustment varied from the actual amount of case mix increase not attributable to real case mix increase by more than 0.25 percentage points, the Secretary shall

make a prospective adjustment to the standardized amounts to correct for the variance.''.

(2) PROPAC RECOMMENDATIONS.—Section 1886(e)(2)(A) (42 U.S.C. 1395ww(e)(2)(A)) is amended by adding at the end the following: ''With respect to subsection (d) hospitals, the Commission's recommendation regarding the appropriate percentage change shall take into account the anticipated difference during the fiscal year between the change in the average weighting factor and the change in real case mix.''.

SEC. 11102. MAINTAINING SAVINGS FROM TEMPORARY REDUCTION IN PPS CAPITAL RATES.

Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following: ''In addition to the reduction described in the preceding sentence, for discharges occurring after October 1, 1996, the Secretary shall reduce by 15.7 percent the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of volume 42 of the Code of Federal Regulations, as in effect on September 30, 1996) and shall reduce by 15.7 percent the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of volume 42 of the Code of Federal Regulations, as in effect on September 30, 1996).''.

SEC. 11103. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

''(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring—

''(I) on or after October 1, 1988 and before October 1, 1996, is equal to 1.89 × (((1+r) to the nth power) −1),

''(II) during fiscal year 1997, is equal to 1.60 × (((1+r) to the nth power) −1),

''(III) during fiscal year 1998, is equal to 1.55 × (((1+r) to the nth power) −1), and

''(IV) during or after fiscal year 1999, is equal to 1.47 × (((1+r) to the nth power) −1),

where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by adding at the end the following: ''except that the Secretary shall not take into account any reductions in the amount of additional payments under subsection

(d)(5)(B)(ii) resulting from the amendments made by section 11103(a) of the Emergency Medicare Protection Act of 1996,''.

(c) ALTERNATIVE TO RESTANDARDIZATION OF COSTS.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended by adding at the end the following:

''(vi) ALTERNATIVE TO RESTANDARDIZATION OF COSTS.—Notwithstanding clauses (i) through (v), if changes in the amount of payment under subsections (d)(3)(E), (d)(5)(B), or (d)(5)(F) would otherwise require the Secretary to restandardize hospital costs under subsection (d)(2)(C), the Secretary may compute payment amounts under this subparagraph in a manner that assures that aggregate payments under this subsection in a fiscal year are not greater or less than those that would have been made in the year if the Secretary had restandardized hospital costs under subsection (d)(2)(C).''.

SEC. 11104. REVISIONS IN DETERMINATION OF AMOUNT OF PAYMENT FOR MEDICAL EDUCATION.

(a) INDIRECT MEDICAL EDUCATION.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended by section 11103(a), is amended—

(A) in clause (ii), by inserting ", subject to clause (vi)" after "clause (i)(II)", and

(B) by adding at the end the following:

"(v) In determining such adjustment with respect to a hospital for discharges occurring on or after October 1, 1996—

"(I) the total number of interns and residents in either a hospital or nonhospital setting may not exceed the number of interns and residents in the hospital with respect to the hospital's cost reporting period ending on or before December 31, 1995, and

"(II) the number of interns and residents who are not primary care residents as defined in subsection (h)(5)(H) or residents in obstetrics and gynecology, may not exceed the number of such residents as of such cost reporting period.

"(vi) For purposes of clause (ii), 'r' may not exceed the ratio of the number of interns and residents as determined under clause (v) with respect to the hospital for its most recent cost reporting period ending on or before December 31, 1995, to the hospital's available beds (as defined by the Secretary) during such cost reporting period.".

(2) PAYMENT FOR INTERNS AND RESIDENTS PROVIDING OFF-SITE SERVICES.—Section 1886(d)(5)(B)(iv) (U.S.C. 42 1395ww(d)(5)(B)(iv)) is amended to read as follows:

''(iv) Effective for discharges occurring on or after October 1, 1996, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted toward the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''.

(b) DIRECT GRADUATE MEDICAL EDUCATION.—

(1) LIMITATION ON NUMBER OF RESIDENTS.—section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following:

''(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1996—

''(i) the total number of full-time equivalent residents (as determined under this paragraph) with respect to a hospital's approved medical residency training pro-

gram may not exceed the number of full-time equivalent residents with respect to the hospital's cost reporting period ending on or before December 31, 1995, and

"(ii) the number of a hospital's full-time-equivalent residents as determined under this paragraph who are not primary care residents (as defined in paragraph (5)(H)) or residents in obstetrics and gynecology may not exceed the number of such residents as of such cost reporting period.

"(G) ADJUSTMENTS TO LIMITATIONS.—The Secretary may adjust the limitations specified in subparagraph (F) if a hospital has a significant increase in the number of primary care or obstetrics and gynecology interns or residents after June 30, 1995.".

(2) PERMITTING PAYMENT TO NONHOSPITAL PROVIDERS.—Section 1886 (42 U.S.C. 1395(ww)) is amended by adding at the end the following:

"(j) PAYMENT TO NONHOSPITAL PROVIDERS.—

"(1) IN GENERAL.—Beginning with cost reporting periods beginning on or after October 1, 1996, the Secretary may establish rules to make payments (in such amounts and in such form, and from each

of the trust funds under this title, as the Secretary considers appropriate) to federally qualified health centers (as defined in section 1861(aa)(4)) and rural health clinics (as defined in section 1861(aa)(2)) for the direct costs of medical education, if such costs are incurred in the operation of an approved medical residency training program described in subsection (h). The Secretary may designate additional entities as eligible organizations for such payments as the Secretary determines to be appropriate.

''(2) COORDINATION WITH PAYMENTS UNDER PART C.—No payments shall be made under paragraph (1) for costs with respect to which payment is made under section 1851F(m).''.

(3) PROHIBITION ON DOUBLE PAYMENTS.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following new flush sentence: ''The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (j) for residents included in the hospital's full-time equivalent residents.''.

(c) COMMISSION ON MEDICAL EDUCATION AND WORKFORCE PRIORITIES.—

(1) IN GENERAL.—There is established within the Department of Health and Human Services a Commission to be known as the National Commission on Medical Education and Workforce Priorities (in this subsection referred to as the ''Commission'').

(2) DUTIES.—The Commission shall have the following responsibilities:

(A) To develop and recommend to the Secretary (in this subsection referred to as the ''Secretary'') specific policies to address the preservation of the research and educational capacity of the Nation's academic health centers and the supply, composition, and support of the future health care workforce including—

(i) the financing of graduate medical education,

(ii) issues relating to children's and specialty hospitals,

(iii) policies regarding international medical school graduates, and

(iv) the relationship of graduate medical education and service generated income.

(B) To make recommendations concerning the most effective allocation of training resources to ensure that the numbers and competencies of health care professionals are responsive to the Nation's needs.

(3) COMPOSITION.—

(A) QUALIFICATIONS.—The Commission shall consist of 15 members appointed by the Secretary, and shall to the extent feasible include—

(i) individuals nationally recognized for expertise in health economics, medical education financing, medial practice, issues relating to the composition of the health care workforce, research on and development of technological and scientific advances in health care, and other related fields; and

(ii) health care professionals including physicians (both faculty and nonfaculty), consumers, a dean and a chief executive officer of an academic health center or a teaching hospital, and representatives from health insurance, managed care, and medical workforce accrediting organizations.

(B) NATIONAL REPRESENTATION.—To the extent feasible, the membership of the Commission—

(i) shall represent the various geographic regions of the United States,

(ii) shall reflect the racial, ethnic, and gender composition of the United States; and

(iii) shall be broadly representative of medical schools, academic health centers, teaching hospitals, and schools involved in the training of nonphysician providers of health services.

(4) TERMS OF OFFICE.—Members of the Commission shall first be appointed no later than January 1, 1997, for a term of two and one-half years.

(5) EX OFFICIO MEMBERS.—In addition to the members appointed pursuant to paragraph (3), the Commission shall include—

(A) the Secretary of Veterans Affairs, and the Secretary of Defense (or a designee of each such official); and

(B) such additional individuals as may be designated by the Secretary from among Federal officers or employees.

(6) CHAIR.—The Secretary shall designate an individual from among the members appointed pursuant to paragraph (3) to serve as the chair of the Commission.

(7) QUORUM.—Nine members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(8) VACANCIES.—Any vacancy in the Commission shall not affect its power to function.

(9) COMPENSATION.—Each member of the Commission who is not otherwise employed by the United States Government shall receive compensation at a rate equal to the daily rate prescribed for GS–18 under the General Schedule under section 5332 of title 5, United States Code, for each day, including travel time, such member is engaged in the actual performance of duties as a member of the Commission. A member of the Commission who is an officer or employee of the United States Government shall serve without additional compensation. All members of the Commission shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in the performance of their duties.

(10) CERTAIN AUTHORITIES AND DUTIES.—In order to carry out the provisions of this subsection, the Commission is authorized to—

(A) collect such information, hold such hearings, and sit and act at such times and places, either as a whole or by subcommittee, and request the attendance and testimony of such witnesses and the production of such documents as the Commission may consider advisable; and

(B) request the cooperation and assistance of Federal departments, agencies, and instrumentalities, and such departments, agencies, and instrumentalities are authorized to provide such cooperation and assistance.

(11) REPORTS.—The Commission shall submit to the Secretary a preliminary report not later than January 1, 1998, and a final report not later than January 1, 1999, making recommendations on the matters specified in paragraph (2).

(12) TERMINATION.—The Commission shall terminate on July 1, 2000.

(13) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary for use in carrying out this subsection such

sums as may be necessary for each of fiscal years 1997, 1998, 1999, and 2000. Funds appropriated for fiscal year 2000 shall remain available until expended, or until the Commission is terminated, whichever occurs first.

SEC. 11105. ELIMINATION OF IME AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by inserting ", for cases qualifying for additional payment under subparagraph (A)(i)," before "the amount paid to the hospital under subparagraph (A)".

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended by inserting ", for cases qualifying for additional payment under subparagraph (A)(i)," before "the amount paid to the hospital under subparagraph (A)".

(c) COST OUTLIER PAYMENTS.—Section 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is amended by striking "exceed the applicable DRG prospective payment rate" and inserting "exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under paragraphs (d)(5)(B) and (d)(5)(F)".

(d) EFFECTIVE DATE.—The amendments in this section apply to discharges occurring on or after October 1, 1996.

SEC. 11106. TREATMENT OF TRANSFER CASES.

Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) of the Act is amended by adding at the end the following:

''(iii) CERTAIN TRANSFERS.—Effective for discharges occurring on or after October 1, 1996, transfer cases (as otherwise defined by the Secretary) shall also include cases in which a patient is transferred from a subsection (d) hospital to a hospital or hospital unit that is not a subsection (d) hospital (under section 1886(d)(1)(B) and implementing regulations) or to a skilled nursing facility for the purpose of receiving extended care services.''.

SEC. 11107. MORATORIUM ON NEW LONG-TERM CARE HOSPITAL EXCLUSIONS.

Section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)) is amended by inserting ''(and had such an average on the date of enactment of the Emergency Medicare Protection Act of 1996)'' before the comma.

SEC. 11108. PAYMENTS TO HOSPITALS EXCLUDED FROM PPS.

(a) REDUCTIONS IN UPDATES.—Section 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

(1) in subclause (V)—

(A) by striking ''through 1997'' and inserting ''through October 1, 1996'', and

(B) by striking ''and'',

(2) by renumbering subclause (VI) as subclause (VII), and

(3) by inserting after subclause (V) the following subclause:

''(VI) fiscal years 1997 through 2002, the market basket percentage increase minus 1.5 percentage points, and''.

(b) REBASING FOR PPS-EXEMPT HOSPITALS.—Section 1886(b)(3)(A)) (42 U.S.C. 1395ww(b)(3)(A)) is amended to read as follows:

''(3)(A)(i) Subject to clauses (ii) and (iii), and except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term 'target amount' means—

''(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital, the average allowable operating costs

of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for such hospital for the hospital's two most recent 12-month cost reporting periods beginning on or after October 1, 1991, subject to the floor and ceiling for target amounts as specified in clause (ii), and increased by the applicable percentage increases under subparagraph (B)(ii) for the hospital's succeeding cost reporting periods beginning before fiscal year 1997, or

''(II) with respect to a later cost reporting period, the target amount for the preceding cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii).

''(ii) Subject to clause (iii), the target amount determined under this subparagraph for a hospital or unit shall not be less than 70 percent nor more than 150 percent of the national mean (adjusted by an appropriate wage index) of the operating costs of inpatient hospital services determined under this paragraph for hospitals (and units thereof as applicable) of each type of hospital described in subsection (d)(1)(B) for the cost reporting periods noted in clause (i)(I) and updated by the applicable percentage increase under subparagraph (B)(ii).

''(iii) In the case of a hospital that does not have a cost reporting period beginning before October 1, 1991—

''(I) with respect to cost reporting periods beginning during the hospital's first two fiscal years of operation, the amount of payment made under this title with respect to operating costs of inpatient hospital services (as defined in subsection (a)(4)) shall be the reasonable costs for providing such services, except that such amount may not exceed 150 percent of the national mean as determined and updated in clause (ii), and

''(II) with respect to a later cost reporting period, clauses (i) and (ii) shall apply to such hospital except that the target amount for the hospital shall be the average allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's first two 12-month cost reporting periods beginning at least one year after the hospital accepts its first patient.''.

(c) EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended by inserting the following after the first sentence: ''The exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital is limited to situations where a hospital's allowable operating costs of inpatient services recognized under this title for the 12-month

cost reporting period exceeds 150 percent of the hospital's target amount (adjusted by the appropriate wage index) for such cost reporting period.''.

(d) ELIMINATION OF INCENTIVE PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended to read as follows:

''(b)(1) Notwithstanding section 1814(b), but subject to the provisions of section 1813 and paragraph (2) of this subsection, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as described in subsection (d)(1)(B)) for a cost reporting period subject to this paragraph—

''(A) are less than or equal to 110 percent of the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge basis shall be equal to such operating costs or the target amount, whichever is less; or

''(B) are greater than the target amount by at least 10 percent, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as applicable) shall be equal to the sum of—

"(i) the target amount, plus

"(ii) an additional amount equal to 50 percent of the amount by which the operating costs exceed 110 percent of the target amount after any exceptions or adjustments are made to such target amount for the cost reporting period (except that such additional amount may not exceed 20 percent of the target amount).".

(e) EFFECTIVE DATE.—Except as otherwise specified, the amendments made by this section apply to cost reporting periods beginning on or after October 1, 1996.

(f) DISCHARGES.—Effective with discharges occurring on or after April 1, 1997, a rehabilitation hospital (or distinct part rehabilitation unit) or long-term hospital that is excluded from the prospective payment system under section 1886(d)(1)(B) shall submit patient assessment data based on a uniform minimum data set defined by the Secretary that can be used to develop a patient's plan of care and could be used to classify patients under a prospective payment system. To the extent the Secretary determines appropriate, the Secretary may require other excluded hospitals to submit patient assessment data.

SEC. 11109. REDUCTIONS TO CAPITAL PAYMENTS FOR PPS-EXEMPT HOSPITALS.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) REDUCTIONS FOR PPS-EXEMPT HOSPITALS.—Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpatient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payment attributable to portions of cost reporting periods occurring on or after October 1, 1996, through fiscal year 2002.''.

SEC. 11110. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR SKILLED NURSING FACILITIES.

(a) BASING UPDATES TO PER DIEM COST LIMITS EFFECTIVE FOR FISCAL YEAR 1996 ON LIMITS FOR FISCAL YEAR 1993.—

(1) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by adding at the end the following: '', except that the limits

effective October 1, 1996, shall be based on the limits effective on October 1, 1992, and shall not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.''.

(2) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by paragraph (1) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(b) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Prospective payments made to skilled nursing facilities under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1996, shall be based on the rates effective for cost reporting periods beginning October 1, 1992, and before October 1, 1993, and shall not take into account any changes in the costs of services occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.

SEC. 11111. INTERIM PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following:

''(e) The Secretary shall, for cost reporting periods beginning on or after October 1, 1996, provide for payment for routine service costs (excluding capital-related costs) of extended care services in accordance with a prospective payment system established by the Secretary in the amounts provided in subsection (f), subject to the exceptions and limitations in subsections (g) and (h).

''(f)(1) The amount of payment under subsection (e) shall be determined on a per diem basis.

''(2) The Secretary shall compute the routine service costs per diem in a base year (determined by the Secretary) for each skilled nursing facility, and shall update the per diem rate on the basis of a market basket and other factors as the Secretary determines appropriate. In determining the per diem rate, the Secretary shall exclude increases in routine service costs associated with fiscal year 1994 and fiscal year 1995.

''(3) The base year routine service costs used to determine the per diem rate applicable to a skilled nursing facility may not exceed the following limits:

''(A) With respect to skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine service costs in a base year (determined by the Secretary) for

freestanding skilled nursing facilities located in rural areas within the same region.

''(B) With respect to skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine service costs in a base year (determined by the Secretary) for freestanding skilled nursing facilities located in urban areas within the same region.

''(C) For purposes of this subsection, urban and rural areas shall be determined in the same manner as for purposes of subsection (a), and the term 'region' shall have the same meaning as under section 1886(d)(2)(D).

''(D) In establishing limits under this subsection, the Secretary may make appropriate adjustments to the labor-related portion of the costs based upon on a wage index and other factors as the Secretary determines appropriate.

''(E) In establishing the routine cost limits under this subsection, the Secretary shall exclude increases in routine service costs associated with fiscal year 1994 and fiscal year 1995.

''(4) Skilled nursing facilities entering the Medicare program subsequent to the base period, determined in subsection (f)(1), shall receive a routine payment rate equal

to the mean per diem routine costs of freestanding skilled nursing facilities in the urban or rural area in which they are located by region. The Secretary shall compute these payment rates using per diem costs in a base year (determined by the Secretary) and shall update the rates on the basis of a market basket and other factors as the Secretary determines appropriate. In determining the payment rates under this paragraph, the Secretary shall exclude increases in routine service costs associated with fiscal year 1994 and fiscal year 1995.

''(5) Effective for cost reporting periods beginning on or after October 1, 1996, low Medicare volume skilled nursing facilities, as described in subsection (d), shall receive payment for routine service costs as otherwise set forth in subsections (e) through (j), except that they may elect to receive payment on the basis of the rates described in subsection (f)(4).

''(6) The Secretary may make prospective adjustments to the routine payment rates to account for changes in facility patient mix (case mix) as the Secretary determines appropriate. A skilled nursing facility must provide the Secretary with the resident assessment data necessary to develop and implement such a system adjustment. Resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State

under section 1819(e)(5), shall be deemed to fulfill this requirement. Such adjustment shall be made in a manner which does not increase expenditures for the routine costs of skilled nursing facility services beyond what would otherwise occur.

''(g)(1) Subject to paragraphs (2) and (3), a facility's per diem payment rate based on the application of subsections (e) and (f) is the greater of—

''(A) its per diem payment amount in the base year, and

''(B) its base year cost per diem up to the regional limit plus any exception amounts that may have been granted in the base year (adjusted by the market basket).

''(2) The payment rate determined under paragraph (1) shall not exceed the facility's cost per diem incurred in the base year adjusted by the market basket.

''(3) Paragraph (1)(A) does not apply if the per diem payment amount in the base year was determined on the basis of an exemption under subsection (f)(4).

''(h) The Secretary, in making determinations on the reasonable costs (both capital and operating) of ancillary services provided by skilled nursing facilities under part A, shall utilize as an upper limit, the carrier fee schedules applicable to such services as specified in sections 1834

and 1848. This subsection shall not have the effect of mitigating other limits on the reasonable costs of ancillary services currently in effect under part A such as those specified in section 1861(v)(5)(A).

''(i) Exceptions, as described in subsection (c), and exemptions, as described in the applicable regulations, are eliminated for cost reporting periods beginning on or after October 1, 1996.''.

(b) CONSOLIDATED BILLING AND UNIFORM CODING.—

(1) IN GENERAL.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (14),

(B) by striking the period at the end of paragraph (15) and adding a semicolon, and

(C) by inserting after paragraph (15) the following:

''(16) which are other than physicians' services, services described by sections 1861(s)(2)(K)(i) through (iii), certified nurse-midwife services, qualified psychologist services, hospice services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a resident of a skilled nursing facility by an entity other

than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility; or

''(17) which are on a claim submitted by a skilled nursing facility under this title, unless the claim uses the HCFA common procedure coding system.''.

(2) CONFORMING AMENDMENT.—Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(A) by striking ''(i)'' and inserting ''(I)'' and striking ''(ii)'' and inserting ''(II)'',

(B) by striking ''(H)'' and inserting ''(H)(i)'', and

(C) by adding at the end the following:

''(ii) in the case of skilled nursing facilities which provide services for which payment may be made under this title, to have all items and services (other than physicians' services, and other than services described by section 1861(s)(2)(K) (i) through (iii), certified nurse-midwife services, qualified psychologist services, hospice services, and services of a certified registered nurse anesthetist)—

''(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

''(II) for which the individual is entitled to have payment made under this title, furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,''.

(3) EFFECTIVE DATE.—The amendments made by this subsection are effective for cost reporting periods beginning on or after October 1, 1996.

SEC. 11112. FULL PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy), as added by section 11111(a), is amended by striking subsections (e) through (i) and inserting the following:

''(e)(1) The Secretary shall provide for payment for all costs of extended care services (including routine service costs, ancillary costs, and capital related costs) in accordance with a prospective payment system established by the Secretary. Such system shall incorporate an adjustment for patient mix (case mix) based on resident assessment data and other data as appropriate. A skilled nursing facility must provide the Secretary with the resident

assessment data necessary to develop and implement such a system adjustment. Resident assessment data required under section 1819(b)(3) using the standard instrument designated by the State under section 1819(e)(5) fulfills this requirement.

''(2) Prior to implementing the prospective payment system described in paragraph (1) in a budget neutral fashion, the Secretary shall reduce, by 7 percent, the per diem rates for routine costs, and the reasonable costs for ancillary services and capital for skilled nursing facilities as such rates and costs are in effect on September 30, 1997.''.

(b) EFFECTIVE DATE.—The amendments made by the preceding subsection apply to cost reporting periods beginning on or after October 1, 1997.

SEC. 11113. SALARY EQUIVALENCY GUIDELINES FOR THERAPY SERVICES.

Section 1861(v)(5) (42 U.S.C. 1395x(v)(5)) is amended—

(1) by redesignating subparagraph (B) as subparagraph (D),

(2) in subparagraph (D), as so redesignated, by adding ''(B), or (C),'' after ''subparagraph (A),'',

(3) by inserting after subparagraph (A) the following:

''(B)(i) Effective for services furnished on or after October 1, 1996, the Secretary shall apply guidelines based on the methodology described in clause (ii) relating to occupational therapy services and speech-language pathology services, and replace guidelines previously established under the subparagraph (A) relating to respiratory therapy services and physical therapy services provided under an arrangement with a provider of services or other organization.

''(ii) The guidelines for each therapy shall be equal to the sum of—

''(I) the sum of an hourly salary rate, plus fringe benefits, plus a rental expense factor (in the same base year), and

''(II) an overhead factor (excluding rental expenses) equal to 28 percent of the amount determined in subclause (I),

adjusted by geographical area using the methodology contained in the final regulation of the Secretary published on page 44928 of volume 48 of the Federal Register on September 30, 1983, updated annually from the base year to the current year by an inflation factor.

''(iii) The data used in establishing the guidelines under clause (ii) shall be—

''(I) in the case of hourly salary rates, for each therapy, the 75th percentile of salaries paid to therapists working full time in an employment relationship in the area, from the most recent available Bureau of Labor Statistics (BLS) hospital salary data for each, increased by 10 percent,

''(II) in the case of fringe benefits, for each therapy, an aggregate factor derived from hospital cost reports ending in fiscal year 1991 for BLS survey areas used in subclause (I),

''(III) in the case of the rental expense factor, for each therapy, an amount derived from local area rental income data compiled by the Building Owners and Managers Association International for 1991, for BLS survey areas used in subclause (I), and

''(IV) in the case of the inflation factor, for each therapy, an amount equal to the average of employment cost indices for wages and benefits of civilian hospital, professional technical and clerical workers, and private executives, administrators and managers, and the Consumer Price Indices (Urban) for Housing and all items less food and energy, weighted by the relative proportion that each component represents of the guidelines amounts.

''(C) Nothing in subparagraph (B) shall preclude the Secretary from updating the guidelines using such data sources and methodology as the Secretary determines to be appropriate, except that any changes to the data sources will be made through rulemaking in a manner that does not increase aggregate spending for such services beyond what would otherwise occur.'', and

(4) by adding at the end the following:

''(E) In applying limitations under section 1861(v)(5), the Secretary shall not recognize an exception for a provider that entered into a written binding contract or contingency contract with a therapist, provider or other organization prior to the date the initial guidelines are published.''.

SEC. 11114. GRADUATE MEDICAL EDUCATION, INDIRECT MEDICAL EDUCATION, AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR MANAGED CARE ENROLLEES.

(a) PAYMENTS FOR GRADUATE MEDICAL EDUCATION PROGRAMS.—Section 1851F, as added by title II, is amended by adding at the end the following:

''(m) PAYMENTS FOR GRADUATE MEDICAL EDUCATION PROGRAMS.—

''(1) ADDITIONAL PAYMENT TO BE MADE.—Starting in calendar year 1997, each contract with

an eligible organization under this section shall provide for an additional payment for Medicare's share of allowable direct graduate medical education costs incurred by such organization for an approved medical residency program.

''(2) ALLOWABLE COSTS.—If the eligible organization has an approved medical residency program that incurs all or substantially all of the costs of the program, the allowable costs for such program shall equal the national average per resident amount times the number of full-time-equivalent residents in the program in nonhospital settings.

''(3) COSTS UNDER CONTRACTS WITH HOSPITALS.—If an eligible organization and a hospital that has an approved medical residency training program both voluntarily enter into a written agreement under which the eligible organization agrees to pay the hospital for direct graduate medical education resident time spent in patient care related activities, then those payments are included within the allowable costs payable under paragraph (1).

''(4) DEFINITIONS.—As used in this subsection—

''(A) the terms 'approved medical residency program', 'direct graduate medical education

costs', and 'full-time-equivalent residents' have the same meanings as under section 1886(h),

"(B) the term 'Medicare's share' means the amount determined by multiplying the eligible organization's allowable costs for an approved medical residency program by the ratio of the number of individuals enrolled with the organization under this section to the total number of individuals enrolled with the organization, and

"(C) the term 'national average per resident amount' means an amount estimated by the Secretary to equal the weighted average amount that would be paid per full-time-equivalent resident under section 1886(h) for the calendar year (determined separately for primary care residency programs as defined under section 1886(h) (including obstetrics and gynecology residency programs) and for other residency programs).".

(b) ADDITIONAL PAYMENTS TO HOSPITALS FOR MANAGED CARE ENROLLEES.—

(1) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—Section 1886(h)(3) (42 U.S.C.

1395ww(h)(3)) is amended by adding at the end the following:

"(D) PAYMENT FOR MANAGED CARE ENROLLEES.—For portions of cost reporting periods occurring on or after January 1, 1997, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a contract with an eligible organization under part C and who are entitled to part A. Subject to subsection (d)(11)(E), the amount of such payment shall be equal to the product of—

"(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

"(ii) the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to individuals who are enrolled in eligible organizations which have contracts under part C and who are entitled to part A.".

(2) ADDITIONAL PAYMENTS TO HOSPITALS FOR SUBSECTION (d) HOSPITALS.—Section 1886(d) (42

U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11)(A) For portions of cost reporting periods occurring on or after January 1, 1997, the Secretary shall provide for an additional payment amount for subsection (d) hospitals for services furnished to individuals who are enrolled under a contract with an eligible organization under part C and who are entitled to part A.

''(B) Subject to subparagraph (E), the amount of such payment shall be determined by multiplying—

''(i) the sum of the amounts determined under subparagraphs (C) and (D), by

''(ii) the product of—

''(I) the number of discharges attributable to individuals who are enrolled in an organization having a contract under Part C and who are entitled to Part A, and

''(II) the estimated average per discharge amount that would otherwise have been paid under section 1886(d)(1)(A) if the individuals had not been enrolled in an organization having a contract under part C.

''(C) The Secretary shall determine an indirect teaching adjustment factor equal to the indirect teaching ad-

justment factor applicable to the hospital under paragraph (5)(B).

''(D) The Secretary shall determine a disproportionate share adjustment factor equal to the disproportionate share adjustment percentage applicable to the hospital under paragraph (5)(F).

''(E)(i) Payments under this paragraph, subsection (h)(3)(D), and section 1851F(1) for services or discharges occurring in a calendar year shall not exceed the annual limit described in clause (iii).

''(ii) At the beginning of each calendar year, if the Secretary determines that the payments described in clause (i) are likely to exceed the limit described in clause (iii), the Secretary shall make an adjustment in the amounts otherwise payable so that total payments will not exceed such limit.

''(iii) The payment limit described in this subclause is the sum, over all counties, of the product of the annual per capita payment adjustment amount, described in clause (iv), and the Secretary's projection of average enrollment in eligible organizations with contracts under part C.

''(iv) The payment adjustment amount described in this clause for a particular county—

''(I) for 1997, is 40 percent of the amount included in the per capita rate of payment for 1996 determined under section 1876(a)(1)(C) for the payment adjustments described in section 1851F(e)(4)(C)(ii)(III) increased by the update factor described in clause (v);

''(II) for 1998 is the per capita payment adjustment amount for 1997 as if ''40 percent'' in subclause (I) was ''100 percent'', increased by the update factor described in clause (v); and

''(III) for 1999 and subsequent years, is the per capita payment adjustment amount for the previous year increased by the update factor described in clause (v).

''(v) The update factor described in clause (iv) is the Secretary's projection for the following calendar year of average per capita growth in the payment adjustments described in section 1851F(e)(4)(C)(ii)(III).

''(vi) Beginning in 1997, during the month of January, the Secretary shall promulgate the payment limit described in clause (iii) for the following calendar year and the payment adjustment described in clause (ii).''.

(c) USE OF INTERIM FINAL REGULATIONS.—The Secretary of Health and Human Services may issue regu-

lations on an interim final basis to implement this section and the amendments made by this Act.

SEC. 11115. SOLE COMMUNITY HOSPITALS.

(a) EXPANDING THE CHOICE OF BASE YEARS.—Section 1886(b)(3)(C) (42 U.S.C. 1395ww(b)(3)(C)) is amended—

(1) by striking ''or'' at the end of clause (iii),

(2) by striking the period at the end of clause (iv) and inserting '', or'', and

(3) by striking the second sentence and inserting in its place the following:

''(v) If such a substitution results in an increase in the target amount for the hospital, there shall be substituted for the base cost reporting period described in clause (i)—

''(I) a hospital's cost reporting period (if any) beginning during fiscal year 1987, or

''(II) beginning with discharges occurring in fiscal year 1997, the average of—

''(aa) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1992 increased (in a compounded manner) by

the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods beginning in fiscal year 1993 and for discharges occurring in fiscal years 1994, 1995, and 1996, and

''(bb) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1993 increased (in a compounded manner) by the applicable percentage increase applied to such hospital under this paragraph for discharges occurring in fiscal years 1994, 1995, and 1996.''.

(b) ELIMINATING THE VOLUME ADJUSTMENT.—Section 1886(d)(5)(D)(ii) (42 U.S.C. 1395ww(d)(5)(D)(ii)) is amended by striking ''In'' at the beginning and inserting ''For cost reporting periods beginning before October 1, 1996, in''.

SEC. 11116. RURAL PRIMARY CARE HOSPITAL PROGRAM.

(a) IN GENERAL.—The heading to section 1820 (42 U.S.C. 1395i–4)) is amended to read as follows:

''RURAL PRIMARY CARE HOSPITAL PROGRAM''.

(b) EXPANSION OF PROGRAM TO ALL STATES.—Section 1820(a)(1) (42 U.S.C. 1395i–4(a)(1)) is amended by striking ''not more than 7''.

(c) MORATORIUM ON NEW ESSENTIAL ACCESS COMMUNITY HOSPITAL DESIGNATIONS.—Section 1820 (42 U.S.C. 1395i–4)) is amended—

(1) in subsections (a)(3) and (b)(1)(C), by striking ''essential access community hospitals or'' after ''as'',

(2) in subsection (c)(1)(B), by striking ''an essential access community hospital or'' after ''is designated as'',

(3) in subsection (d)(1), by striking ''essential access community hospitals or'' after ''facilities in the State as'',

(4) in subsection (d)(2), by striking ''or an essential access community hospital'' after ''rural primary care hospital'',

(5) by repealing subsection (e),

(6) in subsection (g)(1), by amending subparagraph (A) to read as follows:

''(A) at least one hospital that is not a rural primary care hospital, and'',

(7) in subsection (i)—

(A) in the heading, by striking ''HOSPITALS OR'' and ''BY SECRETARY'',

(B) by striking paragraphs (1) and (2)(C),

(C) in paragraph (2)(A)(ii), by striking ''subparagraph (B)'' and inserting ''paragraph (2)'',

(D) by redesignating paragraph (2) as paragraph (1),

(E) by striking the subparagraph designation ''(B)'' and inserting ''(2) FACILITIES DESIGNATED BY THE SECRETARY.—'',

(F) by striking the heading to paragraph (1) (as redesignated by subparagraph (D) of this paragraph) and the subparagraph designation ''(A)'' and inserting ''FACILITIES DESIGNATED BY THE STATE.—'', and

(G) by redesignating clauses (i) through (iii) of paragraph (1) (as redesignated by subparagraph (D) of this paragraph) as subparagraphs (A) through (C), and

(8) in paragraphs (1) and (2) of subsection (k), by striking ''an essential access community hospital or'' each time it appears.

(d) CONTINUING PARTICIPATION OF RURAL PRIMARY CARE HOSPITALS.—Section 1820(i)(1)(A) (42

U.S.C. 1395i–4(i)(1)(A)) (as redesignated by subsection (c)(7) of this section) is amended by inserting before the semicolon the following: ''(or in a State which the Secretary finds would receive a grant under such subsection during a fiscal year if funds were appropriated for grants under such subsection for the fiscal year)''.

(e) DESIGNATION OF NONPROFIT OR PUBLIC HOSPITALS.—Section 1820(f)(1)(A) (42 U.S.C. 1395i–4(f)(1)(A)) is amended by inserting ''is a nonprofit or public hospital, and'' after ''(A)''.

(f) ESTABLISHING A MINIMUM SEPARATION DISTANCE BETWEEN FACILITIES.—Section 1820(f)(1) (42 U.S.C. 1395i–4(f)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (G),

(2) by striking the period at the end of subparagraph (H) and inserting ''; and'', and

(3) by adding at the end the following:

''(I) is located at least a 35-mile drive from any rural primary care hospital or hospital, or is certified by the State as being a necessary provider of health care services to residents in the area, because of local geography or service patterns.''.

(g) REMOVAL OF REQUIREMENT FOR PRIOR COMPLIANCE WITH HOSPITAL STANDARDS.—Section 1820(f)(1)(B) (42 U.S.C. 1395i–4(f)(1)(B)) is amended by striking ''and had not been found, on the basis of a survey under section 1864, to be in violation of any requirement to participate as a hospital under this title''.

(h) LIMITATION ON NUMBER OF INPATIENT BEDS.—The matter in section 1820(f)(1)(F) (42 U.S.C. 1395i–4(f)(1)(F)) preceding clause (i) is amended by striking ''6'' and inserting ''15''.

(i) LIMITATION ON LENGTH OF INPATIENT STAYS.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended—

(1) in the matter in paragraph (1)(F) preceding clause (i), by striking ''subject to paragraph (4),'',

(2) in paragraph (1)(F)(i), by striking ''72 hours'' and inserting ''96 hours'', and

(3) by striking paragraph (4).

(j) CONFORMING CHANGE.—Section 1814(a)(8) (42 U.S.C. 1395f(a)(8)) is amended by striking ''within 72 hours'' and inserting ''within 96 hours''.

(k) PERMITTING RURAL PRIMARY CARE HOSPITALS TO MAINTAIN SWING BEDS.—Section 1820(f)(3) (42 U.S.C. 1395i–4(f)(3)) is amended—

(1) in the first sentence, by striking ''are used for the furnishing of extended care services'' through ''paragraph (1)(F))'', and

(2) by amending the second sentence to read as follows: ''Nothing in this subsection shall be construed to prohibit a rural primary care hospital from entering into an agreement under section 1883 under which its facilities are used for the furnishing of extended care services.''.

(l) CONFORMING CHANGE.—Section 1883 (42 U.S.C. 1395tt) is amended by striking ''hospital'' each place it appears and inserting ''hospital or rural primary care hospital''.

(m) CHANGE IN PAYMENT METHODOLOGY.—Section 1814(l)(1) (42 U.S.C. 1395f(l)(1)) is amended by striking ''services—'' and all that follows through the period and inserting ''services is the reasonable cost of the rural primary care hospital in providing such services, as determined under section 1861(v).''.

(n) ELIMINATION OF DEADLINE FOR DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM.—Section 1814(l) (42 U.S.C. 1395(l)(1)) is amended—

(1) by striking paragraph (2), and

(2) by striking ''(l)(1)'' and inserting ''(l)''.

(o) NO CHANGE IN PAYMENT TO EXISTING ESSENTIAL ACCESS COMMUNITY HOSPITALS.—

(1) IN GENERAL.—Section 1886(d)(5)(D)(iii)(III) (42 U.S.C. 1395ww(d)(5)(D)(iii)(III)) is amended—

(A) by inserting ''was'' after ''is located in a rural area and'', and

(B) by striking ''under section 1820(i)(1).'' and inserting ''under section 1820(i)(1) as in effect on the day before effective date of the Emergency Medicare Protection Act of 1996. The application of a facility that was submitted to the State for designation as an essential access community hospital prior to January 1, 1996, and on which the State had not acted on by that date shall be deemed to have been approved by the Secretary prior to the enactment of the Emergency Medicare Protection Act of 1996 if, within 2 months of enactment—

''(aa) the State in which the facility is located determines that such facility meets the criteria for essential access community hospital designation described in section 1820(e) as in effect prior to the enactment of such Act (or

solely fails to meet the criteria in section 1820(e)(2)), and

''(bb) the Secretary determines the facility meets the criteria described in section 1820(i)(1)(A) (i) and (iii) as in effect prior to the enactment of such Act.''.

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(D)(v) (42 U.S.C. 1395ww(d)(5)(D)(v)) is amended—

(A) by inserting ''was'' after ''is located in a rural area and'', and

(B) by inserting ''as in effect on the day before effective date of the Emergency Medicare Protection Act of 1996'' after ''section 1820(I)(1)''.

(p) CONFORMING AMENDMENT.—Section 1820(c)(3) (42 U.S.C. 1395i–4(c)(3)) is amended by striking ''(i)(2)(C)'' and inserting ''(i)(2)''.

(q) TECHNICAL AMENDMENT.—Section 1820(f)(1)(A) (42 U.S.C. 1395i–4(f)(1)(A)) is amended by striking ''section 1866(d)(2)(D)'' and inserting ''section 1886(d)(2)(D)''.

(r) MEDICAL ASSISTANCE FACILITIES.—Limited service rural hospitals participating in a demonstration described in section 4008(i)(1) of the Omnibus Budget Rec-

onciliation Act of 1990 (and any facilities that have applied for inclusion in the demonstration as of the date of the enactment of this Act and that would have been included by the Secretary under provisions applicable as of the date of enactment) shall be deemed to be rural primary care hospitals as long as they continue to meet the requirements of the demonstration protocol relating to staffing, services, quality assurance, and related factors.

SEC. 11117. RURAL REFERRAL CENTERS.

(a) PERMANENT GRANDFATHERING OF RURAL REFERRAL CENTER STATUS.—

(1) IN GENERAL.—Section 1886(d)(5)(C) (42 U.S.C. 1395ww(d)(5)(C)) is amended by adding at the end the following:

''(iii) Notwithstanding any other provisions of law, any hospital that was classified as a rural referral center under this subparagraph on September 30, 1994, shall continue to be classified as a rural referral center for fiscal year 1995 and each subsequent fiscal year with respect to payments under this title, unless the area in which the hospital is located is designated as an MSA for such fiscal year.''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to comply as a rural referral center under section 1886(d)(5)(C)

as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) to reclassify the hospital as being located in an urban area for fiscal year 1995 or fiscal year 1996, the Secretary of Health and Human Services shall—

(A) notify the hospital of the failure to qualify,

(B) provide an opportunity for the hospital to decline the reclassification, and

(C) if the hospital—

(i) declines the reclassification, administer the Social Security Act (other than section 1886(d)(8)(D)) for such fiscal year as if the decision by the Review Board had not occurred, or

(ii) fails to decline the reclassification, administer the Social Security Act without regard to paragraph (1).

(b) GEOGRAPHIC RECLASSIFICATION AND GRADUATED AREA WAGE INDEX FOR RURAL REFERRAL CENTERS.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended by adding at the end the following new clauses:

''(iv) Notwithstanding clause (i) and section 412.230(e)(1)(iii) of title 42, Code of Federal Regulations (relating to criteria for use of an area's wage index), with respect to applications requesting a change in a hospital's geographic classification pursuant to subparagraph (C)(i)(II) for fiscal year 1998 and subsequent fiscal years, the Secretary shall treat an eligible hospital (as defined in clause (v)) as if it were located in another area.

''(v) For purposes of clause (iv), an ''eligible hospital'' means a hospital that—

''(I) is classified as a rural referral center under paragraph (5)(C);

''(II) submits an application in accordance with this paragraph requesting a change in the hospital's geographic classification pursuant to subparagraph (C)(i)(II); and

''(III) meets all other applicable requirements and standards except that the hospital's average hourly wage (as determined by the Secretary) is less than 108 percent of the average hourly wage of the hospitals in the area in which the hospital is located.''.

(2) WAGE INDEX.—Section 1886(d)(8)(C) (42 U.S.C. 1395ww(d)(8)(C)) is amended by adding at the end the following new clause:

''(v) Notwithstanding any other provision of law—

''(I) in the case of an eligible hospital (as defined in paragraph (10)(D)(iv) whose average hourly wage (as determined by the Secretary) is equal to or greater than 104 percent and less than 108 percent of the average hourly wage of the hospitals in the area in which the hospital is located, the wage index for such hospital shall be equal to the sum of—

''(aa) the wage index for the area in which the hospital is located; and

''(bb) 66 percent of the difference between the wage index for the area to which the hospital is reclassified (for a hospital treated as if it were located in such area, and the amount determined under item (aa);

''(II) in the case of an eligible hospital whose average hourly wage (as determined by the Secretary) is greater than 100 percent and less than 104 percent of the average hourly wage of the hospitals in the areas in which the hospital is located, the wage index of such hospital shall be determined as if the reference in

subclause (I) to '66 percent' were a reference to '33 percent'.''.

(c) EFFECTIVE DATE.—The amendments made by subsection (b) apply to applications submitted to the Medicare Geographic Classification Review Board under section 1886(d)(10)(C) for reclassification in fiscal year 1998, and for each subsequent application period.

SEC. 11118. TELEMEDICINE.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended—

(1) in the title heading by striking out ''AND HEALTH PROMOTION'' and inserting '', HEALTH PROMOTION AND TELEMEDICINE DEVELOPMENT'';

(2) by inserting after the title heading the following:

''PART A—HEALTH INFORMATION AND HEALTH PROMOTION'';

and

(3) by adding at the end the following:

''PART B—TELEMEDICINE DEVELOPMENT

''GRANT PROGRAM FOR PROMOTING THE DEVELOPMENT OF RURAL TELEMEDICINE NETWORKS.

SEC. 1711. (a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible enti-

ties in accordance with this subsection to promote the development of rural telemedicine networks.

''(b) GRANTS FOR DEVELOPMENT OF RURAL TELEMEDICINE.—The Secretary, acting through the Office of Rural Health Policy, shall award grants to eligible entities that have applications approved under subsection (d) for the purpose of expanding access to health care services for individuals in rural areas through the use of telemedicine. Grants shall be awarded under this section to—

''(1) encourage the initial development of rural telemedicine networks;

''(2) expand existing networks;

''(3) link existing networks together; or

''(4) link such networks to existing fiber optic telecommunications systems.

''(c) ELIGIBLE ENTITY DEFINED.—For the purposes of this section the term 'eligibility entity' means hospitals and other health care providers operating in a health care network of community-based providers that includes at least three of the following—

''(1) community or migrant health centers;

''(2) local health departments;

''(3) community mental health centers;

''(4) nonprofit hospitals;

''(5) private practice health professionals, including rural health clinics; or

''(6) other publicly funded health or social services agencies.

''(d) APPLICATION.—To be eligible to receive a grant under this section an eligible entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require, including a description of—

''(1) the need of the entity for the grant;

''(2) the use to which the entity would apply any amounts received under such grant;

''(3) the source and amount of non-Federal funds that the entity will pledge for the project funded under the grant; and

''(4) the long-term viability of the project and evidence of the providers commitment to the network.

''(e) PREFERENCE IN AWARDING GRANTS.—In awarding grants under this section, the Secretary shall give preference to applicants that—

''(1) are health care providers operating in rural health care networks or that propose to form such networks with the majority of the providers in

such networks being located in a medically underserved area or health professional shortage area;

''(2) can demonstrate broad geographic coverage in the rural areas of the State, or States in which the applicant is located;

''(3) propose to use funds received under the grant to develop plans for, or to establish, telemedicine systems that will link rural hospitals and rural health care providers to other hospitals and health care providers;

''(4) will use the amounts provided under the grant for a range of health care applications and to promote greater efficiency in the use of health care resources;

''(5) demonstrate the long-term viability of projects through use of local matching funds (in cash or in-kind); and

''(6) demonstrate financial, institutional, and community support and the long-range viability of the network.

''(f) USE OF AMOUNTS.—Amounts received under a grant awarded under this section shall be utilized for the development of telemedicine networks. Such amounts may be used to cover the costs associated with the development of telemedicine networks and the acquisition of telemedi-

cine equipment and modifications or improvements of telecommunications facilities, including—

''(1) the development and acquisition through lease or purchase of computer hardware and software, audio and visual equipment, computer network equipment, modification or improvements to telecommunications transmission facilities, telecommunications terminal equipment, interactive video equipment, data terminal equipment, and other facilities and equipment that would further the purposes of this section;

''(2) the provision of technical assistance and instruction for the development and use of such programming equipment or facilities;

''(3) the development and acquisition of instructional programming;

''(4) the development of projects for teaching or training medical students, residents, and other health professions students in rural training sites about the application of telemedicine;

''(5) transmission costs, maintenance of equipment, and compensation of specialists and referring practitioners;

''(6) the development of projects to use telemedicine to facilitate collaboration between health care providers; and

''(7) such other uses that are consistent with achieving the purposes of this section as approved by the Secretary.

''(g) PROHIBITED USE OF AMOUNTS.—Amounts received under a grant awarded under this section shall not be used for—

''(1) expenditures to purchase or lease equipment to the extent the expenditures would exceed more than 60 percent of the total grant funds; or

''(2) expenditures for indirect costs (as determined by the Secretary) to the extent the expenditures would exceed more than 10 percent of the total grant funds.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

''(i) DEFINITION.—For the purposes of this section, the term 'rural health care network' means a group of rural hospitals or other rural health care providers (including clinics, physicians, and nonphysicians primary care providers) that have entered into a relationship with each other or with nonrural hospitals and health care providers

for the purpose of strengthening the delivery of health care services in rural areas or specifically to improve their patients' access to telemedicine services. At least 75 percent of hospitals and other health care providers participating in the network shall be located in rural areas.''.

SEC. 11119. ESTABLISHMENT OF RURAL HEALTH OUTREACH GRANT PROGRAM.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''PART O—RURAL HEALTH OUTREACH GRANTS

''RURAL HEALTH OUTREACH GRANT PROGRAM.

''SEC. 3990 (a) IN GENERAL.—The Secretary may make grants to demonstrate the effectiveness of outreach to populations in rural areas that do not normally seek or do not have access to health or mental health services. Grants shall be awarded to enhance linkages, integration, and cooperation in order to provide health or mental health services, to enhance services, or increase access to or utilization of health or mental health services.

''(b) MISSION OF THE OUTREACH PROJECTS.—Projects funded under subsection (a) should be designed to facilitate the integration and coordination of services in or among rural communities in order to address the

needs of populations living in rural or frontier communities.

''(c) COMPOSITION OF PROGRAM.—

''(1) CONSORTIUM ARRANGEMENT.—To be eligible to participate in the grant program established under subsection (a), an applicant entity shall be a consortium of three or more separate and distinct entities formed to carry out an outreach project under subsection (b).

''(2) CERTAIN REQUIREMENTS.—A consortium under paragraph (1) shall be composed of three or more public or private nonprofit health care or social service providers. Consortium members may include local health departments, community or migrant health centers, community mental health centers, hospitals or private practices, or other publicly funded health or social service agencies.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $30,000,000 for fiscal year 1997, and such sums as may be necessary for each of the fiscal years 1998 through 2001.''.

SEC. 11120. MEDICARE-DEPENDENT, SMALL, RURAL HOSPITAL PAYMENT EXTENSION.

(a) SPECIAL TREATMENT EXTENDED.—

(1) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(g)) is amended—

(A) in clause (i), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1996, and before October 1, 2000,'';

(B) by striking ''and'' at the end of clause (ii)(I);

(C) by striking the period at the end of clause (ii)(II) and inserting a semicolon;

(D) by adding at the end of clause (ii) the following:

''(III) for discharges occurring during any cost reporting period beginning on or before October 1, 1996, and before October 1, 2000, 50 percent of the amount by which the hospital's target amount (as defined in subclause (IV)) for the cost reporting period exceeds the amount determined under paragraph (1)(A)(iii); and

''(IV) for purposes of subclause (III), a facility's target amount for the cost reporting period is as defined in subsection (b)(3)(D) except that the base cost reporting period shall be determined in accordance with subsection (b)(3)(C)(v)(II), as amend-

ed in the Emergency Medicare Protection Act of 1996.''; and

(E) In clause (iv)—

(i) in subclause (III), by striking ''and'',

(ii) in subclause (IV), by striking the period and inserting a comma, and

(iii) by adding at the end the following:

''(V) for cost reporting periods beginning on or after October 1, 1996, for which not less than 60 percent of its inpatient days or discharges during the cost reporting periods beginning in fiscal year 1992 and fiscal year 1993 were attributable to inpatients for which payments are made under this subsection.''.

(2) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''September 30, 1994,'' and inserting ''September 30, 1994, and for cost reporting periods beginning on or after October 1, 1996, and before October 1, 2000,'';

(B) in clause (ii), by striking ''and'' at the end;

(C) in clause (iii) by striking the period at the end and inserting a comma; and

(D) by adding at the end the following new clauses:

''(iv) with respect to discharges occurring during fiscal year 1997, the target amount shall be defined as the average of—

''(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1992 increased (in a compounded manner) by the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods beginning in fiscal year 1993 and for discharges occurring in fiscal years 1994, 1995, and 1996, and

''(II) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1993 increased (in a

compounded manner) by the applicable percentage increase applied to such hospital for discharges occurring in fiscal years 1994, 1995, and 1996, and

''(v) with respect to discharges occurring during fiscal years 1998 through 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).''.

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA–93 (42 U.S.C. 1395ww note) is amended by striking ''or fiscal year 1994'' and inserting '', fiscal year 1994, fiscal year 1995, fiscal year 1996, fiscal year 1997, fiscal year 1998, or fiscal year 1999''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to discharges occurring during portions of cost reporting periods beginning on or after October 1, 1996.

Subtitle B—Provisions Relating to Part B

SEC. 11121. PAYMENTS FOR PHYSICIANS' SERVICES.

(a) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.—

(1) UPDATE—

(A) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395W–4(d)(3)) is amended to read as follows:

"(3) UPDATE.—

"(A) IN GENERAL.—Unless Congress otherwise provides, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1997 shall be determined as follows:

"(i) 1997.—The update for 1997 shall be the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of section 11121 of the Emergency Medicare Protection Act of 1996.

"(ii) SUBSEQUENT YEARS.—The update for years beginning with 1998 shall be equal to the product of—

"(I) 1 plus the Secretary's estimate of the percentage increase in the MEI (described in section 1842(i)(3)) for the year (divided by 100, and

"(II) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

"(B) UPDATE ADJUSTMENT FACTOR.—The 'update adjustment factor' for a year is equal to the quotient (as estimated by the Secretary) of—

"(i) the difference between (I) the sum of the allowed expenditures for physicians' services furnished during each of the fiscal years 1995 through the year involved, and (II) the sum of the amount of actual expenditures for physicians' services furnished during each of the fiscal years 1995 through the previous year, divided by

"(ii) the allowed expenditures for physicians' services furnished during the fiscal year.

"(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B), allowed expenditures for physicians' services shall be determined as follows (as estimated by the Secretary):

"(i) 1995.—In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during fiscal year 1995.

"(ii) SUBSEQUENT YEARS.—In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous fiscal year increased by the sustainable growth rate under subsection (f) for the fiscal year.

"(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B), the update in the conversion factor under this paragraph for a year may not be—

"(i) greater than 1.03 plus the Secretary's estimate of the percentage increase in the MEI (described in section 1842(i)(3)) for the year (divided by 100), minus 1 and multiplied by 100, or

"(ii) less than 0.9175 plus the Secretary's estimate of the percentage increase in the MEI (described in section

1842(i)(3)) for the year (divided by 100), minus 1 and multiplied by 100.''.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) apply to physicians' services furnished on or after January 1, 1997.

(2) CONFORMING AMENDMENTS.—

(A) SECTION 1848(d)(2).—Section 1848(d)(2)(A) (42 U.S.C. 1395w–4(d)(2)(A)) is amended—

(i) in the matter preceding clause (i)—

(I) by striking ''(or factors) in the conversion factor (or factors)'' and inserting ''in the conversion factor'',

(II) by striking ''(beginning with 1991)'' and inserting ''(beginning with 1996)'', and

(III) by striking the second sentence,

(ii) by amending clause (ii) to read as follows:

''(ii) such factors as enter into the calculation of the update adjustment factor as described in paragraph (3)(B); and'',

(iii) by amending clause (iii) to read as follows:

''(iii) access to services.'',

(iv) by striking clauses (iv), (v), and (vi), and

(v) by striking the last sentence.

(B) SECTION 1848(d)(2)(B).—Section 1848(d)(2)(B) (42 U.S.C. 1395w–4(d)(2)(B)) is amended—

(i) by striking ''and'' at the end of clause (iii),

(ii) by striking the period at the end of clause (iv) and inserting ''; and'', and

(iii) by adding at the end the following new clause:

''(v) changes in volume or intensity of services.''.

(C) REDESIGNATION OF SUBPARAGRAPH.—Section 1848(d)(2) (42 U.S.C. 1395w–4(d)(2)) is further amended—

(i) by striking subparagraphs (C), (D), and (E),

(ii) by redesignating subparagraph (F) as subparagraph (C), and

(iii) in subparagraph (C), as redesignated, by striking ''(or updates) in the conversion factor (or factors)'' and inserting ''in the conversion factor''.

(b) REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.—

(1) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

''(2) SPECIFICATION OF GROWTH RATE.—

''(A) FISCAL YEAR 1996.—The sustainable growth rate for all physicians' services for fiscal year 1996 shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (described in section 1842(i)(3)) for 1996 (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from fiscal year 1995 to fiscal year 1996,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real

gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 1 percentage point, and

"(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law (including the Emergency Medicare Protection Act of 1996), determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d), minus 1 and multiplied by 100.

"(B) SUBSEQUENT YEARS.—The sustainable growth rate for all physicians' services for fiscal year 1997 and each subsequent year shall be equal to the product of—

"(i) 1 plus the Secretary's estimate of the percentage increase in the MEI for the fiscal year involved (described in section 1842(i)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 1 percentage point, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

''(3) DEFINITIONS.—In this subsection:

''(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory test and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to an eligible organization enrollee.

''(B) ELIGIBLE ORGANIZATION ENROLLEE.—The term 'eligible organization enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title through an eligible organization with a contract under part C (and, through 2000, enrollment with an organization with a contract under section 1876(h).''.

(2) CONFORMING AMENDMENTS.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended—

(A) in the heading, by striking ''VOLUME PERFORMANCE STANDARD RATES OF INCREASE'' and inserting ''SUSTAINABLE GROWTH RATE'',

(B) in paragraph (1)—

(i) in the heading, by striking ''VOLUME PERFORMANCE STANDARD RATES OF INCREASE'' and inserting ''SUSTAINABLE GROWTH RATE'',

(ii) in subparagraph (a), in the matter preceding clause (i), by striking ''performance standard rates of increase'' and inserting ''sustainable growth rate'', and

(iii) in subparagraph (A), by striking ''HMO enrollees'' each place it appears and inserting ''eligible organization enrollees'',

(C) in subparagraph (B), by striking ''performance standard rates of increase'' and inserting ''sustainable growth rate'', and

(D) in subparagraph (C)—

(i) in the heading, by striking ''PERFORMANCE STANDARD RATES OF INCREASE'' and inserting ''SUSTAINABLE GROWTH RATE'',

(ii) in the first sentence, by striking ''with 1991), the performance standard rates of increase'' and all that follows through the first period and inserting ''with 1997), the sustainable growth rate

for the fiscal year beginning in that year.'', and

(iii) in the second sentence, by striking ''January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990'' and inserting ''January 1, 1997, the sustainable growth rate for fiscal year 1997''.

(c) ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1996.—

(1) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (E), and

(B) by inserting after subparagraph (B) the following:

''(C) SPECIAL RULES FOR 1996.—The single conversion factor for 1996 under this subsection shall be $35.42 for all physicians' services (other than services covered in subparagraph (D)), except that during 1996, conversion factors shall be used for surgical services and nonsurgical services (as defined in subsection (j)(1)) at the levels otherwise established by the Secretary for such services.

''(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—If the Secretary establishes a separate relative value scale and conversion factor for anesthesia services for a year, the separate conversion factor for anesthesia services shall be updated from the conversion factor that applied for such services in the previous year—

''(i) for 1997, by the same percentage change as for the category of surgical services as defined in subsection (j)(1), and

''(ii) for 1998 and thereafter, by the same percentage change as would apply for all physicians' services as determined under paragraph (3).''.

(2) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(A) by striking ''(or factors)'' each place it appears in subsection (d)(1) (A) and (E)(ii) (as redesignated by paragraph (1)(A),

(B) in subsection (d)(1)(A), by striking ''or updates'',

(C) in subsection (d)(1)(E)(ii) (as redesignated by paragraph (1)(A)), by striking ''(or updates)'', and

(D) in subsection (i)(1)(C), by striking ''conversion factors'' and inserting ''the conversion factor''.

SEC. 11122. PRACTICE EXPENSE RELATIVE VALUE UNITS.

(a) EXTENSION TO 1997.—Section 1848(c)(2)(E)(i) (42 U.S.C. 1395w–4(c)(2)(E)(i)) is amended—

(1) by striking ''and'' at the end of subclause (II),

(2) by striking the period at the end of subclause (III) and inserting '', and'', and

(3) by inserting at the end the following:

''(IV) 1997, by an additional 25 percent of such excess.''.

(b) CHANGE IN FLOOR ON REDUCTIONS AND SERVICES COVERED.—Clauses (ii) and (iii)(II) of section 1848(c)(2)(E) (42 U.S.C. 1395w–4(c)(2)(E)) are each amended by inserting ''(or 115 percent in the case of 1997)'' after ''128 percent''.

SEC. 11123. SINGLE FEE FOR SURGERY.

(a) IN GENERAL.—Section 1848(a) (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following:

''(5) SINGLE FEE FOR SURGERY.—

''(A) GENERAL RULE.—Payment under this part for surgical services (as defined by the

Secretary under subsection (j)(1)), when a separate payment is also made for the services of a physician or other practitioners acting as an assistant at surgery, may not (except as provided in subparagraph (B)), when added to the separate payment made for the services of that other practitioner, exceed the amount that would be paid for the surgical services if a separate payment were not made for the services of that practitioner.

''(B) EXCEPTIONS.—The Secretary may specify surgery procedures or situations to which subparagraph (A) does not apply.''.

(b) CONFORMING AMENDMENT.—Section 1848(g)(2)(D) (42 U.S.C. 1395w–4(g)(2)(D)) is amended by inserting ''(or the lower amount under subsection (a)(5))'' after ''subsection (a)''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1997.

SEC. 11124. INCENTIVES TO CONTROL HIGH VOLUME FOR IN-HOSPITAL PHYSICIANS' SERVICES.

(a) IN GENERAL.—

(1) LIMITATIONS DESCRIBED.—Part B of title XVIII is amended by adding at the end the following:

"SEC. 1849. INCENTIVES TO CONTROL HIGH VOLUME FOR IN-HOSPITAL PHYSICIANS' SERVICES.

"(a) SERVICES SUBJECT TO REDUCTION.—

"(1) DETERMINATION OF HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1998), the Secretary shall determine for each hospital—

"(A) the hospital-specific per admission relative value under subsection (b)(2) for the following year, and

"(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (b)(1).

"(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (c)) the

amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an individual who is a member of the hospital's medical staff.

"(3) TIMING OF DETERMINATION; NOTICE TO MEDICAL STAFFS AND CARRIERS.—Not later than October 1 of each year (beginning with 1998), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff under paragraph (1).

"(b) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

"(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUES.—

"(A) URBAN HOSPITALS.—In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection for 1999 and 2000 is equal to 125 percent and for years after 2000 is 120 percent of the median of 1997 hospital-

specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

''(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1999 and each succeeding year, is equal to 140 percent of the median of the 1997 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

''(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

''(A) IN GENERAL.—The hospital-specific per admission relative value projected for a hospital (other than a teaching hospital) for a calendar year, shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among

hospitals (as determined by the Secretary under subparagraph (C)).

''(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a calendar year shall be equal to the sum of—

''(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, and

''(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall determine such equivalent relative value unit per admission for

interns and residents based on the best available data and may make such adjustment in the aggregate.

''(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

''(c) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician's service that is subject to a reduction under subsection (a) during a year shall be reduced 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (a)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

''(d) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

"(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 2000), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission relative value shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under subsection (b)(2)(C)). Notwithstanding any other provision of this title, no payment may be made under this part for any physician's service furnished by a member of a hospital's medical staff to an inpatient of the hospital during a year unless such claim is submitted to the Secretary for payment for such service not later than 90 days after the last day of the year.

"(2) RECONCILIATION WITH REDUCTIONS TAKEN.—In the case of a hospital for which the pay-

ment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the hospital were reduced under this section for a year—

"(A) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (c), including interest at an appropriate rate determined by the Secretary; and

"(B) if the actual average per admission relative value for such hospital's medical staff during the year exceeded the allowable average per admission relative value applicable to the hospital's medical staff under subsection (a)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff the amount withheld under subsection (c) multiplied by the 'final ratio', including interest at an appropriate

rate determined by the Secretary. The final ratio described in the previous sentence shall be determined by dividing the difference between the initial ratio and 0.85, by 0.15, where the initial ratio is determined by dividing the medical staff's allowable average per admission relative value for a year (as determined under subsection (a)(1)) by the medical staff's actual hospital-specific per admission relative value for such year, but in no case shall the initial ratio be less than 0.85.

''(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have one year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate withhold amount made by the carrier.

''(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement de-

scribed in paragraph (2)(B) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff, on a pro rata basis according to the proportion of expenditures for physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

''(e) DEFINITIONS.—In this section, the following definitions apply:

''(1) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

''(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

''(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

''(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

''(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

''(B) if such physician provides at least one service to a Medicare beneficiary in such hospital.

''(2) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given such terms under section 1886(d)(2)(D).

''(3) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6).

''(4) HOSPITAL.—The term 'hospital' means a subsection (d) hospital as defined in section 1886(d).

''(5) PHYSICIANS' SERVICES.—The term 'physicians' services' means those services described in section 1848(j)(3).''.

(2) CONFORMING AMENDMENTS.—

(A) SECTION 1833(a).—Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting ''subject to reduction under section 1849)'' after ''1848(a)(1)''.

(B) SECTION 1848(a).—Section 1848(a)(1)(B) (42 U.S.C. 1395w–4(a)(1)(B)) is

amended by striking ''this subsection,'' and inserting ''this subsection and section 1849,''.

(b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w–4(g)(A)(i)) is amended by striking ''beneficiary,'' and inserting ''beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form),''.

(c) EFFECTIVE DATES.—

(1) SUBSECTION (a).—The amendments made by subsection (a) apply to services furnished on or after January 1, 1999.

(2) SUBSECTION (b).—The amendments made by subsection (b) apply to services furnished on or after January 1, 1998.

11125. AMBULATORY SURGICAL CENTER SERVICE UPDATES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended—

(1) by striking ''a fiscal year (beginning with fiscal year 1996)'' and inserting ''fiscal year 1996, and for other fiscal years beginning with 2003'', and

(2) by inserting after the subparagraph designation ''(C)'' the following: ''Notwithstanding the

second sentence of subparagraph (A) or the second sentence of subparagraph (B), with respect to fiscal years 1997 through 2002, the Secretary shall increase amounts for facility services by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved, reduced by two percentage points for fiscal years 1997 through 2002.''.

SEC. 11126. OXYGEN AND OXYGEN EQUIPMENT, OTHER DURABLE MEDICAL EQUIPMENT AND ORTHOTICS AND PROSTHETICS.

(a) IN GENERAL.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking ''and'' at the end of subparagraph (A),

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, 1995, and 1996'', and

(ii) by striking the period at the end and adding ''; and'', and

(C) by adding at the end the following:

''(C) for each of the years 1997 through 2002, 0 percent; and

''(D) for a subsequent year, the percentage increase in the Consumer Price Index for all urban consumers (United States urban average) for the 12-month period ending with June of the previous year.''.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) in clause (i), by striking the comma at the end and inserting a semicolon,

(B) by striking ''and'' at the end of clause (iii) and inserting a semicolon, and

(C) by redesignating clause (iv) as clause (v), and by adding after clause (iii), the following clause:

''(iv) for 1996, 3.0 percent, and for 1997 through 2002, 0 percent, and''

(b) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1993, 1994, 1995, and 1996''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(v) in each subsequent year, is 90 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year.''.

SEC. 11127. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—Subparagraph (B)(i)(II) of section 1833(i)(3) (42 U.S.C. 1395l(i)(3)) and subparagraph (B)(i)(II) of section 1833(n)(1) (42 U.S.C. 1395l(n)(1)) are each amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) EFFECTIVE DATE.—The amendments made by this section are effective for services furnished during por-

tions of cost reporting periods occurring on or after October 1, 1996.

SEC. 11128. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''1992 through 1998'' and inserting ''beginning with 1992''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''1991 through 1998'' and inserting ''beginning with 1991''.

SEC. 11129. PROSPECTIVE PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

''(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

''(1) IN GENERAL.—Notwithstanding any other provision of this title, with respect to hospital outpatient services designated by the Secretary and furnished during years beginning with January 1, 2002, the amount of payment made for the services determined under this part shall be determined

under a prospective payment system established by the Secretary in accordance with this subsection.

''(2) SYSTEM REQUIREMENTS.—Under the system established by the Secretary under this subsection—

''(A) the Secretary shall develop a classification system to reflect the hospital outpatient services furnished under this part;

''(B) groups of procedures and visits shall be established so that procedures and visits within each group are comparable clinically and with respect to the use of resources;

''(C) the Secretary shall, using data from the most recent year available, established relative payment weights for groups based on median hospital costs and shall determine the frequency of each group;

''(D) the Secretary shall determine a wage adjustment factor to adjust for relative differences in labor and labor-related costs across geographic regions;

''(E) the Secretary shall establish other adjustments as determined to be necessary to ensure equitable payments, such as outlier adjust-

ments or adjustments for certain classes of hospitals; and

"(F) the Secretary shall examine potential methodologies to control for unnecessary increases in the volume of the services subject to payment under this section.

"(3) GROUP PRICES.—On the basis of the weights and frequencies described in paragraph (2)(C), the Secretary shall establish prices for each group such that 20 percent of the sum of the group prices (taking into account appropriate adjustments described in paragraph (2)(D) and paragraph (2)(E)), multiplied by the frequencies, shall equal the coinsurance target determined in paragraph (4).

"(4) COINSURANCE TARGET.—For purposes of determining the group prices in paragraph (3), the coinsurance target shall equal the Secretary's estimate of the projected total amount of coinsurance payments that would be made under this part with respect to outpatient hospital services furnished during 2002 (without regard to the provisions of this section) as determined under section 1866(a)(2)(A)(ii).

"(5) COINSURANCE AMOUNTS.—Beginning in 2002, the amount of coinsurance on hospital out-

patient services shall be calculated as 20 percent of the group price determined under paragraph (3), adjusted for relative differences in the cost of labor and adjusted for other factors determined by the Secretary.

''(6) MEDICARE'S PAYMENT AMOUNT.—

''(A) IN GENERAL.—The Secretary shall—

''(i) establish an expenditure target based on an estimate of total projected Medicare payments made to hospitals for outpatient department services in 2002 without regard to the provisions of this section; and

''(ii) determine a Medicare payment factor which when applied to the sum of the group prices (taking into account appropriate adjustments described in paragraph (2)(D) and paragraph (2)(E)) multiplied by projected frequencies in 2002 shall equal the expenditure target.

''(B) 2002 AND THEREAFTER.—Beginning on January 1, 2002, the amount of payment made for outpatient department services shall be equal to the applicable group price, adjusted for differences in the cost of labor and adjusted

for other factors determined by the Secretary, multiplied by the Medicare payment factor.

''(7) UPDATES.—

''(A) IN GENERAL.—Beginning on January 1, 2003, and until such time as the Medicare payment factor is 0.80, the Medicare payment factor shall be increased each year by the percentage increase applicable under section 1886(b)(3)(B)(iii) for the fiscal year in which the year begins.

''(B) RULE FOR UPDATES AFTER MEDICARE PAYMENT FACTOR BECOMES 0.80.—During and after the first calendar year following the date on which the Medicare payment factor is 0.80—

''(i) the Medicare payment factor shall be frozen; and

''(ii) the group price shall be increased each year by the percentage increase applicable under section 1886(b)(3)(B)(iii) for the fiscal year in which the year begins.

''(8) PERIODIC REVIEW AND ADJUSTMENTS TO GROUP PRICES.—

''(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups,

the relative payment weights, and the wage and other adjustments described in paragraph (2) and the group prices described in paragraph (3) to take into account changes in medical practice, changes in technology, the addition of new procedures, new cost data and other relevant information and factors.

''(B) BUDGET NEUTRALITY FOR ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then such adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if such adjustments has not been made.''.

(b) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A) Section 1833(i)(3)(A) (42 U.S.C. 1395l(i)(3)(A)) is amended by inserting ''before January 1, 2002'' after ''furnished'' and by striking ''in a cost reporting period''.

(B) Section 1833(a)(4) (42 U.S.C. 1395l(a)(4)) is amended by deleting the semi-

colon following ''subsection (i)'' and inserting ''or subsection (t);''.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 1395l(n)(1)(A)) is amended by inserting ''and before January 1, 2002'' after ''October 1, 1988,'' and after ''October 1, 1989,''.

(B) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by deleting the semicolon following ''subsection (n)'' and inserting ''or (t);''.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting ''before January 1, 2002,'' after ''(i)'';

(B) in clause (ii), by inserting ''before January 1, 2002,'' after ''(ii)'';

(C) by redesignating clause (iii) as clause (iv); and

(D) by striking ''or'' at the end of clause (ii) and inserting the following new clause:

''(iii) on or after January 1, 2002, the amount determined under subsection (t), or''.

(4) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following new sentence: ''In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable coinsurance amount established under such system.''.

SEC. 11130. WAIVE COST-SHARING FOR MAMMOGRAPHY.

(a) DIAGNOSTIC MAMMOGRAPHY.—Section 1861(s) (42 U.S.C. 1395x(s)) is amended—

(1) in paragraph (3), by striking ''including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act'',

(2) by striking ''and'' at the end of paragraph (15),

(3) by striking the period at the end of paragraph (16) and inserting ''; and'', and

(4) by adding at the end the following:

''(17) diagnostic mammography, if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act.''.

(b) PAYMENT FOR SCREENING MAMMOGRAPHY.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking '', subject to the deductible established under section 1833(b),'' and ''80 percent of''.

(c) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(1) by striking ''and'' before ''(4)'', and

(2) by inserting the following before the period at the end: '', and (5) such deductible shall not apply with respect to screening and diagnostic mammography described in section 1861(s)(13) and section 1861(s)(17)''.

(d) WAIVER OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (O), and

(2) by inserting before the semicolon at the end of subparagraph (P) the following '', and (Q) with respect to diagnostic mammography described in section 1861(s)(17), the amount paid shall be 100

percent of the fee schedule amount provided under section 1848''.

(e) WAIVER OF COINSURANCE IN HOSPITAL OUTPATIENT DEPARTMENTS.—The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to items and services described in section 1861(s)(13), with respect to items and services described in section 1861(s)(17),''.

(f) EFFECTIVE DATE.—The amendments made by the preceding subsections apply to services furnished on or after January 1, 1997 through December 31, 2000.

SEC. 11131. ANNUAL MAMMOGRAMS.

(a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 49.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iv), by striking ''but under 65 years of age,'' and

(2) by striking clause (v).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after January 1, 1997 through December 31, 2000.

SEC. 11132. COVERAGE OF COLORECTAL SCREENING.

(a) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following:

''(d) COVERAGE AND DEFINITION OF COLORECTAL SCREENING PROCEDURES.—

''(1) IN GENERAL.—Notwithstanding any other provision of this part, payment may be made only for periodic colonoscopy screening procedures conducted consistent with the frequency permitted under this subsection.

''(2) FREQUENCY LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS.—Subject to revision by the Secretary under paragraph (5), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer if the test is performed—

''(A) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph, or

''(B) in the case of any other individual, within the 11 months following the month in which a previous screening fecal-occult blood test was performed.

''(3) PERIODIC COLORECTAL SCREENING PROCEDURES FOR INDIVIDUALS NOT AT HIGH RISK FOR COLORECTAL CANCER.—

''(A) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (5), no payment may be made under this part for a periodic colorectal screening procedure provided to an individual for the purpose of early detection of colon cancer if the procedure is performed—

''(i) on an individual under 50 years of age; or

''(ii) within the 59 months after a previous periodic colorectal screening procedure.

''(B) PERIODIC COLORECTAL SCREENING PROCEDURE DEFINED.—The term 'periodic colorectal screening procedure' means a flexible sigmoidoscopy, barium enema screening procedure, or other screening procedure for colorectal cancer as determined by the Secretary.

''(4) SCREENING PROCEDURES FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

''(A) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (5), no payment may be made under this part for eligible procedures defined in subparagraph (B) for individuals at high risk for colorectal cancer for

the purpose of early detection of colon cancer if the procedure is performed within the 47 months following the month in which a previous eligible procedure was performed.

''(B) ELIGIBLE PROCEDURES.—Procedures eligible for payment under this part for screening for individuals at high risk for colorectal cancer for the purpose of early detection of colorectal cancer shall include a screening colonscopy, barium enema screening procedures, or other screening procedures for colorectal cancer as the Secretary determines appropriate.

''(C) FACTORS CONSIDERED IN ESTABLISHING CRITERIA FOR DETERMINING INDIVIDUALS AT HIGH RISK.—In establishing criteria for determining whether an individual is at high risk for colorectal cancer for purposes of this paragraph, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

''(5) REVISION OF FREQUENCY.—

''(A) REVIEW.—The Secretary shall review periodically the appropriate frequency for per-

forming screening fecal-occult blood tests, screening flexible sigmoidoscopies, barium enema screening procedures, screening colonoscopies, and other colorectal screening procedures determined appropriate by the Secretary, based on age and such other factors as the Secretary believes to be pertinent.

''(B) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under subparagraph (a), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection.''.

(b) CONFORMING AMENDMENTS.—

(1) SECTION 1833(a).—Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by striking ''subsection (h)(1),'' and inserting ''subsection (h)(1) or section 1834(d)(1),''.

(2) SECTION 1862(a).—Section 1862(a) (42 U.S.C. 1395y(a)) is amended)—

(A) in paragraph (1)—

(i) by striking ''and'' at the end of subparagraph (E),

(ii) by striking the semicolon at the end of subparagraph (F) and inserting ", and", and

(iii) by adding at the end the following:

"(G) in the case of screening fecal-occult blood tests, screening flexible sigmoidoscopies, barium enema screening procedures, screening colonoscopies, and other colorectal screening procedures determined appropriate by the Secretary, provided for the purpose of early detection of colon cancer, which are performed more frequently than is covered under section 1834(d);", and

(B) in paragraph (7), by striking "paragraph (1)(B) or under paragraph (1)(F)" and inserting "subparagraphs (B), (F), or (G) of paragraph (1)".

(c) EFFECTIVE DATE.—The amendments made by the preceding subsections apply to services furnished on or after January 1, 1997 through December 31, 2000.

SEC. 11133. PAYMENTS FOR VACCINES AND VACCINE ADMINISTRATION.

(a) PAYMENT AMOUNTS FOR THE ADMINISTRATION OF CERTAIN VACCINES.—

(1) IN GENERAL.—Section 1833(k) (42 U.S.C. 1395l(k)) is amended to read as follows:

''(k)(1) The payment amount under this part for the administration of a vaccine described in section 1861(s)(10) shall be equal to—

''(A)(i) for a vaccine administered in 1997 not in connection with the furnishing of another service, $9, and

''(ii) for a vaccine administered in 1997 in connection with the furnishing of another service, $4, and

''(B) for a vaccine administered in any subsequent year, the amount determined under subparagraph (A), or under this subparagraph, for the previous year, increased by the update under section 1848(d)(3) for that subsequent year for physicians' services (described in section 1848(d)(3)(A)(ii)(I)).

''(2) For a limitation on actual charges for items and services described in section 1861(s)(10), see paragraphs (1) and (2) of section 1848(g).''.

(2) CONFORMING AMENDMENT TO SECTION 1832(a)(1).—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking ''and (D)'' and inserting '', (D), and (K)''.

(3) CONFORMING AMENDMENTS TO SECTION 1832(a)(2).—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(A) in subparagraph (B), by striking ''described in subparagraph (G) or subparagraph (I)'' and inserting ''or services described in subparagraph (G), (I), or (K)'',

(B) in subparagraph (D), by inserting before the semicolon the following: '', other than, in either case, services described in subparagraph (K)'',

(C) in subparagraph (H), by inserting before the semicolon the following: '', other than services described in subparagraph (K)'',

(D) in subparagraph (I), by striking the final ''and'',

(E) in subparagraph (J), by striking the period and inserting ''; and'', and

(F) by adding at the end the following:

''(K) administration of vaccines by providers of services, or as rural health clinic or federally qualified health center services.''.

(4) CONFORMING AMENDMENTS TO SECTION 1833(a)(1).—Section 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended—

(A) by striking ''items and services described'' and inserting ''vaccines listed'', and

(B) by inserting at the end the following: ''and, with respect to the administration of those vaccines, the amounts described in subsection (k)(1),''.

(5) CONFORMING AMENDMENTS TO SECTION 1833(a)(42).—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(A) in the matter preceding subparagraph (A), by striking ''and (I)'' and inserting '', (I), and (K)'', and

(B) in the matter in subparagraph (A) preceding clause (i), by striking ''items and services described'' and inserting ''vaccines listed''.

(6) CONFORMING AMENDMENT TO SECTION 1833(a)(3).—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by striking ''items and services described'' and inserting ''vaccines listed''.

(7) CONFORMING AMENDMENTS TO SECTION 1833(a)(6).—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)) is amended—

(A) by inserting ''other than services described in section 1832(a)(2)(K)'' after ''services'', and

(B) by striking ''and''.

(8) CONFORMING AMENDMENT TO SECTION 1833(a)(7).—Section 1833(a)(7) (42 U.S.C. 1395l(a)(7)) is amended by striking the period and inserting ''; and''.

(9) CROSS REFERENCE.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended by adding at the end the following:

''(8) in the case of services described in section 1832(a)(2)(k), the amount described in subsection (k)(1).''.

(10) CONFORMING AMENDMENT TO SECTION 1834(g).—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by inserting ''(other than services described in section 1832(a)(2)(K))'' after ''hospital services''.

(11) CONFORMING AMENDMENTS TO SECTION 1842(b).—

(A) INITIAL MATTER IN PARAGRAPH (3)(B).—The matter in section 1842(b)(3)(B) (42 U.S.C. 1395u(b)(3)(B)) preceding clause (i) is amended by inserting '', where payment under this part for a service is on a basis other than a cost basis,'' after ''carrier, and''.

(B) PARAGRAPH (3)(B)(ii).—Section 1842(b)(3)(B)(ii)(I) (42 U.S.C. 1395u(b)(3)(B)(ii)(I)) is amended by inserting ''(or other payment basis)'' after ''reasonable charge''.

(12) CONFORMING AMENDMENTS TO SECTION 1848(g).—

(A) PARAGRAPH (1).—The first sentence of section 1848(g)(1) (42 U.S.C. 1395w–4(g)(1)) is amended by inserting '', or items and services described in section 1861(s)(10),'' after ''service''.

(B) PARAGRAPH (2).—Section 1848(g)(2)(C) (42 U.S.C. 1395w–4(g)(2)(C)) is amended by adding at the end the following: ''For items and services described in section 1861(s)(10) furnished in a year after 1994, the ''limiting charge'' shall be 115 percent of the applicable amount described in section 1833(k)(1).''.

(b) ELIMINATION OF COINSURANCE AND DEDUCTIBLE FOR HEPATITIS B VACCINE.—Section 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)), the matter in subparagraph (A) of section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) preceding clause (i), section 1833(a)(3) (42

U.S.C. 1395l(a)(3)), paragraph (1) of the first sentence of section 1833(b) (42 U.S.C. 1395l(b)), and the third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) are each amended by striking ''1861(s)(10)(A)'' and inserting ''1861(s)(10)''.

(c) REPEAL OF OBSOLETE PROVISIONS.—

(1) SOCIAL SECURITY ACT.—Section 1861(s)(10)(A) (42 U.S.C. 1395x(s)(10)(A)) is amended by striking '', subject to section 4071(b) of the Omnibus Reconciliation Act of 1987,''.

(2) OBRA–1987.—Section 4071(b) of OBRA-1987 is repealed.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to services furnished on or after January 1, 1997 through December 31, 2000.

SEC. 11134. DIABETES SCREENING BENEFITS.

(a) DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), is amended—

(A) by striking ''and'' at the end of subparagraph (N);

(B) by striking ''and'' at the end of subparagraph (O); and

(C) by inserting after subparagraph (O) the following new subparagraph:

''(P) diabetes outpatient self-management training services (as defined in subsection (pp)); and''.

(2) DEFINITION.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES

''(pp)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by or under arrangements with a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administrations of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is an individual or entity that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) an individual or entity meets the quality standards described in this paragraph if the individual or entity meets quality standards established by the Secretary, except that the individual or entity shall be deemed to have met such standards if the individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by the American Diabetes Association as meeting standards for furnishing the services.''.

(3) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848(a) of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including the

American Diabetes Association, in determining the relative value for such services under section 1848(c)(2) of such Act.

(b) BLOOD GLUCOSE MONITORS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AS DURABLE MEDICAL EQUIPMENT.—Section 1861(n) (42 U.S.C. 1395x(n)) is amended by striking the semicolon in the first sentence and inserting the following: ''and includes blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the American Diabetes Association);''.

(2) PAYMENT FOR MONITORS BASED ON METHODOLOGY FOR INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT.—Section 1834(a)(2)(A) of such Act (42 U.S.C. 1395m(a)(2)(A)) is amended—

(A) by striking ''or'' at the end of clause (ii);

(B) by adding ''or'' at the end of clause (iii); and

(C) by inserting after clause (iii) the following new clause:

''(iv) which is a blood-testing monitor for an individual with diabetes,''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after January 1, 1997 through December 31, 2000.

SEC. 11135. RESPITE BENEFIT.

(A) ENTITLEMENT.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)), as amended by section 11133(a), is amended by—

(1) striking ''and'' at the end of subparagraph (J),

(2) striking the period at the end of subparagraph (K) and inserting ''; and'', and

(3) inserting at the end the following new subparagraph:

''(L) respite services for no more than 32 hours each year.''.

(b) CONDITIONS AND LIMITATIONS ON PAYMENT.—

(1) PAYMENT RATE.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended by—

(A) adding a new subparagraph (G) to read as follows:

''(G)(i) with respect to respite services, payment shall be made at a rate equal to $7.50 per hour for 1996 and at a rate to be deter-

mined by the Secretary in subsequent years; and

''(ii) notwithstanding any provisions of section 1861(v), in the case of respite services furnished by a home health agency (or other organization designated by the Secretary pursuant to regulations), payment to the agency or other organization for respite services may not exceed 100 percent of the hourly respite allowance times the number of hours of respite for which the agency authorizes payment.''.

(2) CONDITIONS OF PAYMENT.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended by—

(A) striking ''and'' at the end of subparagraph (E),

(B) striking the period at the end of subparagraph (F) and inserting ''; and'', and

(C) inserting at the end the following new subparagraph:

''(G) In the case of respite services, the individual for whom payment is claimed is severely impaired due to irreversible dementia (the individual has scored three or more errors on the Short Portable Mental Status Question-

naire) and either needs assistance in at least one out of five activities of daily living (bathing, dressing, transferring, toileting, and eating) or in at least one out of four instrumental activities of daily living (meal preparation, medication management, money management, and telephoning), or needs constant supervision because of one or more behavioral problems, as defined by the Secretary.''.

(3) FAMILY DESIGNATION OF RESPITE SERVICES PROVIDER AND CARE GIVER.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended by adding at the end the following new sentences: ''In the case of respite services that are the subject of the certification described in subparagraph (G), the entity or individual providing the care for which respite is sought shall designate a respite services caregiver either through a home health agency or (if the Secretary designates other organizations to provide or arrange for such services) other organization. The agency or organization shall determine the amount of respite entitlement remaining in the calendar year and inform the entity or individual of the extent to which respite services may be authorized. When services have been provided, the entity or indi-

vidual shall inform the agency or organization, which shall then make payment to the caregiver. Where additional payment is made on behalf of the beneficiary, the agency or organization shall assure that the entity or individual is informed of the limits applicable to payments for such services. No payment may be made under this title for respite services if the per-hour charge to the patient for care by respite aides exceeds by more than $2 the hourly rates established under this title.''.

(c) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (m)—

(A) by striking ''and'' at the end of paragraph (6);

(B) by adding ''and'' at the end of paragraph (7); and

(C) by inserting after paragraph (7) the following:

''(8) respite services as described in subsection (oo);'',

(2) in subsection (o)—

(A) by striking ''and'' at the end of paragraph (6);

(B) by adding ''and'' at the end of paragraph (7); and

(C) by inserting after paragraph (7) the following:

''(8) agrees to provide or arrange for respite services as described in subsection (oo);'', and

(3) by adding after subsection (nn) the following:

''RESPITE SERVICES; RESPITE AIDES; RESPITE PROVIDERS

''(oo)(1) The term 'respite services' means temporary care provided to individuals who meet the requirements of section 1835(a)(2) for the purposes of ensuring periodic time-off for co-resident primary informal caregivers. Although respite providers may provide assistance with personal care or household maintenance activities, their primary function is to provide protective supervision for persons with Alzheimer's and related dementias whose memory, orientation, judgment, and reasoning abilities have become so impaired that, for safety's sake, they require the constant attention or close physical proximity of another person at all or almost all hours of the day or night.

''(2) The term 'respite aides' means individuals who have been designated by the Secretary as qualified to act as caregivers for purposes of providing the services described in paragraph (1). Respite aides may be nurse aides

who meet the requirements of section 1819(b)(5), home health aides who meet the requirements of section 1891(a)(3), or other individuals licensed by the State or recognized by the Secretary as having the skills necessary to provide such services.

''(3) The term 'respite providers' means organizations identified by the Secretary in regulations as qualified to provide or arrange for respite services under this title. The Secretary may establish by regulation such requirements for respite providers as the Secretary determines appropriate.''.

(d) PAYMENT FROM SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND FOR RESPITE SERVICES FURNISHED TO INDIVIDUALS WITH ONLY HOSPITAL INSURANCE COVERAGE.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3),

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

(3) by inserting at the end the following new paragraph:

''(5) respite services, described in section 1832(a)(2)(L), except that such services shall be

furnished under the Supplementary Medical Insurance Program.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall be effective for services beginning in fiscal year 2002.

SEC. 11136. PAYMENTS TO PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS.

(a) COVERAGE IN HOME AND AMBULATORY SETTINGS IN WHICH A FACILITY OR PROVIDER FEE IS NOT BILLED FOR PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (i)—

(A) by striking ''or'' at the end of subclause (II); and

(B) by inserting ''or (IV) in a home or ambulatory setting in which a facility or provider fee is not billed (as defined by the Secretary),'' following ''shortage area,''; and

(2) in clause (iii)—

(A) by striking ''in a rural'' and inserting ''in (I) a rural''; and

(B) by inserting '', or (II) in a home or ambulatory setting in which a facility or pro-

vider fee is not billed (as defined by the Secretary),'' after ''(as defined in 1886(d)(2)(D))''.

(b) PAYMENTS TO PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS IN HOME AND AMBULATORY SETTINGS IN WHICH A FACILITY OR PROVIDER FEE IS NOT BILLED.—

(1) IN GENERAL.—Section 1833(r)(1) (42 U.S.C. 1395l(r)(1)) is amended by striking ''clinical nurse specialist services provided in a rural area)'' and inserting ''clinical nurse specialist services)''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking ''clauses (i), (ii), or (iv)'' and inserting ''clauses (i) or (ii)''.

(B) Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(k)) is amended—

(i) in clause (i), by inserting ''and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service,'' after ''are performed,'';

(ii) in clause (ii), by inserting ''and such services and supplies furnished as an

incident to such service as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service, and'' after ''are performed,'';

(iii) in clause (iii), by striking '', and'' at the end and inserting a period; and

(iv) by striking clause (iv).

(c) PAYMENT UNDER THE FEE SCHEDULE TO PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS IN HOME AND AMBULATORY SETTINGS IN WHICH A FACILITY OR PROVIDER FEE IS NOT BILLED.—

(1) PAYMENT.—Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i) by striking ''(i), (ii), or (iv)'' and inserting ''(i) and (ii)''.

(2) TECHNICAL AMENDMENT.—Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i) by striking ''a physician assistants'' and inserting ''physician assistants''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1997.

Subtitle C—Provisions Relating to Parts A and B

SEC. 11141. CENTERS OF EXCELLENCE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following:

''CENTERS OF EXCELLENCE

''SEC. 1889. (a) IN GENERAL.—The Secretary shall use a competitive process to contract with centers of excellence for coronary artery bypass surgery or other heart procedures, knee surgery, hip surgery, and such other services as the Secretary determines to be appropriate. Payment under this title shall be made for services subject to such contracts on the basis of negotiated or all-inclusive rates as follows:

''(1) COVERAGE OF URBAN AREA.—The center shall cover services provided in an urban area (as defined in section 1886(d)(2)(D)) for years beginning with fiscal year 1997.

''(2) SAVINGS REQUIRED.—The amount of payment made by the Secretary to the center under this title for services covered under the project shall be less than the aggregate amount of the payments that the Secretary would have made to the center for such services had the project not been in effect.

''(3) TYPES OF SERVICES.—The Secretary shall make payments to the center on such a basis for the following services furnished to individuals entitled to benefits under this title:

''(A) Facility, professional, and services relating to the procedure.

''(B) Such other services as the Secretary and the center may agree to cover under the agreement.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to services furnished on or after October 1, 1996.''.

SEC. 11142. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: ''In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before October 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) (42 U.S.C. 1395x(v)(1)(L)(ii)) of the Social Security Act.

SEC. 11143. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by inserting ''and before October 1, 1996,'' after ''July 1, 1987'' in subclause (III),

(2) by striking the period at the end of the matter following subclause (III), and inserting '', and'', and

(3) by adding at the end the following new subclause:

''(IV) October 1, 1996, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''July 1, 1996'' and inserting ''October 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

''(iv) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, but before October 1, 1999, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—

''(I) costs determined under the preceding provisions of this subparagraph, or

''(II) an agency-specific per beneficiary annual limitation calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994, and on or before December 31, 1994, based on reasonable costs (including nonroutine medical supplies), updated by the home health market basket index. The per beneficiary limitation shall be multiplied by the agency's unduplicated census count of patients (entitled to benefits under this title) for the year subject to the limitation to determine the aggregate agency-specific per beneficiary limitation.

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the following rules shall apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limitation shall be equal to the mean of these limits (or the Secretary's best estimates thereof) applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or name shall not be considered new providers for payment purposes.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

''(vi) Home health agencies whose cost or utilization experience is below 125 percent of the mean national or census region aggregate per beneficiary cost or utilization experience for 1994, or best estimates thereof, and whose year-end reasonable costs are below the agency-specific per beneficiary limitation, shall receive payments equal to 50 percent of the difference between the agency's reasonable costs and its limit for fiscal years 1997, 1998, and 1999. Such payments may not exceed 5 percent of such agency's aggregate Medicare reasonable cost in a year.

''(vii) Effective January 1, 1997, or as soon as feasible, the Secretary shall modify the agency-specific per

beneficiary annual limitation described in clause (iv) to provide for regional or national variations in utilization. For purposes of determining payment under clause (iv), the limit shall be calculated through a blend of 75 percent of the agency-specific cost or utilization experience in 1994 with 25 percent of the national or census region cost or utilization experience in 1994, or the Secretary's best estimates thereof.''.

(d) USE OF INTERIM FINAL REGULATIONS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall implement the payment limits described in section 1861(v)(1)(L)(iv) of the Social Security Act by publishing in the Federal Register a notice of interim final payment limits by August 1, 1996, and allowing for a period of public comment thereon. Payments subject to these limits will be effective for cost reporting periods beginning on or after October 1, 1996, without the necessity for consideration of comments received, but the Secretary shall, by Federal Register notice, affirm or modify the limits after considering those comments.

(e) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary shall expand research on a prospective payment system for home health agencies that shall tie prospective payments to an episode of care, including an intensive ef-

fort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(f) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary may require all home health agencies to submit such additional information as the Secretary considers necessary for the development of a reliable case mix system.

SEC. 11144. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

Title XVIII is amended by adding at the end the following:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1893. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall, for cost reporting periods beginning on or after October 1, 1999, provide for payments for home health services in accordance with a prospective payment system, which pays home health agencies on a per episode basis, established by the Secretary.

''(b) ELEMENTS OF SYSTEM.—Such a system shall include the following:

''(1) BASED ON A PER EPISODE AMOUNT.—All services covered and paid on a reasonable cost basis under the Medicare home health benefit as of the date of the enactment of the Emergency Medicare

Protection Act of 1996, including medical supplies, shall be subject to the per episode amount. In defining an episode of care, the Secretary shall consider an appropriate length of time for an episode, the use of services, and the number of visits provided within an episode, potential changes in the mix of services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current audited cost report data available to the Secretary.

''(2) USE OF CASE MIX.—The Secretary shall employ an appropriate case mix adjustment that explains a significant amount of the variation in cost.

''(3) ANNUAL ADJUSTMENTS.—The episode payment amount shall be adjusted annually by the home health market basket index. The labor portion of the episode amount shall be adjusted for geographic differences in labor-related costs based on the most current hospital index.

''(4) OUTLIERS.—The Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

''(5) PRORATION OF EPISODE PAYMENTS.—A home health agency shall be responsible for coordinating all home health care for a beneficiary. If a beneficiary elects to transfer to, or receive services from, another home health agency within an episode period, the episode payment shall be prorated between home health agencies.

''(c) SAVINGS.—Prior to implementing the prospective system described in subsections (a) and (b) in a budget-neutral fashion, the Secretary shall first reduce, by 15 percent, the payments based on the cost limits, per beneficiary limits, and actual costs, described in section 1861(v)(1)(L)(iv), as such limits are in effect on September 30, 1999.''.

SEC. 11145. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

''(g) A home health agency shall submit claims for payment of home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1997.

SEC. 11146. ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.

(a) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting ''and'' at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as (D).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to payments made on or after the implementation of prospective payments as described in section 1893 of the Social Security Act, as added by section 11144 of this Act.

SEC. 11147. PERMANENT EXTENSION OF CERTAIN SECONDARY PAYER PROVISIONS.

(a) WORKING DISABLED.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended by striking clause (iii).

(b) INDIVIDUAL WITH END-STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it occurs and inserting ''18-month'', and

(2) by striking the second sentence.

(c) IRS-SSA-HCFA DATA MATCH.—

(1) SOCIAL SECURITY ACT.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) INTERNAL REVENUE CODE.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

Subtitle D—Medicare Part B Premium

SEC. 11161. PART B PREMIUM.

(a) IN GENERAL.—The first, second, and third sentences of section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) are amended to read as follows: ''The Secretary shall, during September of each year, determine and promulgate a monthly premium rate for the succeeding calendar year. That monthly premium rate shall be equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over,

determined according to paragraph (1), for that succeeding calendar year.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—Section 1839 (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2), by striking ''(b) and (e)'' and inserting ''(b), (c), and (f)'',

(2) in the third sentence of subsection (a)(3), as amended by subsection (a) or this section—

(A) by inserting ''rate'' after ''premium'', and

(B) by striking ''and the derivation of the dollar amounts specified in this paragraph'',

(3) by striking subsection (e), and

(4) by redesignating subsection (g) as (e) and inserting that subsection after subsection (d).

(c) EFFECTIVE DATE.—The amendments made by this section apply to premiums for months after December 1995.

TITLE II—EXPANDED MEDICARE CHOICE

SEC. 11201. EXPANDED CHOICE UNDER MEDICARE.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 the following:

''OPTION TO ENROLL IN MANAGED CARE PLANS

''SEC. 1805. Every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only shall be eligible to enroll under part C with any eligible organization with which the Secretary has entered into a contract under part C and which serves the geographic area in which the individual resides.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to enrollments whose periods begin after 1996.

SEC. 11202. BROADER CHOICE AMONG MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part C (42 U.S.C. 1395x et seq.) as part D, and

(2) by inserting after part B the following new part:

''PART C—MANAGED CARE ORGANIZATIONS

''SEC. 1851A. TYPES OF MANAGED CARE ORGANIZATIONS.

''(a) ELIGIBLE ORGANIZATIONS.—For purposes of this part, the term 'eligible organization' means a public or private entity, organized under the laws of any State, that is—

''(1) a qualified health maintenance organization (QHMO),

''(2) a competitive medical plan (CMP),

''(3) a preferred provider organization (PPO),

''(4) a provider sponsored organization (PSO), or

''(5) any other managed care organization that meets the requirements of subparagraphs (C), (D), and (E) of subsection (c)(1) and any additional requirements developed by the Secretary.

''(b) QUALIFIED HEALTH MAINTENANCE ORGANIZATION (QHMO).—For purposes of this part, the term 'qualified health maintenance organization' means such an organization (as defined in section 1310(d) of the Public Health Service Act) that meets the requirements of subparagraphs (B) and (E) of subsection (c)(1).

''(c) COMPETITIVE MEDICAL PLAN (CMP).—

''(1) IN GENERAL.—For purposes of this part, the term 'competitive medical plan' means an entity that meets the following requirements:

''(A) MINIMUM SERVICES TO ALL MEMBERS.—The entity provides to enrolled members at least the following health care services:

"(i) Physicians' services performed by physicians (as defined in section 1861(r)(1)).

"(ii) Inpatient hospital services.

"(iii) Laboratory, X-ray, emergency, and preventive services.

"(iv) Out-of-area coverage.

"(B) PROVISION OF PHYSICIANS' SERVICES.—The entity provides physicians' services primarily—

"(i) directly through physicians who are either employees or partners of such organization, or

"(ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

"(C) COMPENSATION ON PREPAID RISK BASIS.—The entity is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind

of health care service actually provided to a member.

''(D) ASSUMPTION OF RISK.—The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that such entity may—

''(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

''(ii) obtain insurance or make other arrangements for the cost of health care services listed in subparagraph (A) provided to its enrolled members other than through the entity because medical necessity required their provision before they could be secured through the entity,

''(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

"(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

"(E) FISCAL SOUNDNESS; PROVISION AGAINST INSOLVENCY.—The entity meets standards for fiscal soundness (including standards for provision against the risk of insolvency) applicable to federally qualified health maintenance organizations under title XIII of the Public Health Service Act.

"(2) EXCEPTION FOR CERTAIN GRANDFATHERED CONTRACTS.—Paragraph (1)(A)(ii) shall not apply to an entity which had contracted with a single State agency administering a State plan approved under title XIX for the provision of services (other than inpatient hospital services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970.

"(d) PREFERRED PROVIDER ORGANIZATION (PPO).—

"(1) IN GENERAL.—For purposes of this part, the term 'preferred provider organization' means an entity that meets the following requirements:

"(A) MINIMUM SERVICES TO ALL MEMBERS.—The entity provides at least physicians' services performed by physicians (as defined in section 1861(r)(1)).

"(B) PROVISION OF PHYSICIAN SERVICES; FISCAL SOUNDNESS.—The entity meets the requirements of subparagraphs (B) and (E) of subsection (c)(1).

"(C) ASSUMPTION OF RISK.—The entity meets the requirements of subsection (c)(1)(D) with respect to members enrolled with the organization under this part.

"(2) DETERMINATION OF PRIVATE MEMBERSHIP.—In applying the provisions of sections 1851E(g) and 1851F (e)(1)(B)(i) and (f)(1)(B)(i) (concerning minimum private enrollment) to an organization that meets the requirements of paragraph (1), individuals for whom the organization has assumed substantial financial risk shall be considered to be members of the organization.

"(e) PROVIDER SPONSORED ORGANIZATION (PSO).—

"(1) IN GENERAL.—For purposes of this part, the term 'provider sponsored organization' means an entity that meets the following requirements:

"(A) TYPE OF ENTITY.—The entity is a hospital, a group of affiliated hospitals, or an affiliated group consisting of a hospital or hospitals and physicians or other entities that furnish health services.

"(B) MINIMUM SERVICES TO ALL MEMBERS.—The entity provides at least physicians' services performed by physicians (as defined in section 1861(r)(1)) and inpatient hospital services.

"(C) DIRECT PROVISION OF SERVICES.—The entity provides directly a substantial portion of the services covered under this title (as determined by the Secretary, which may vary for rural or underserved areas).

"(D) ASSUMPTION OF RISK.—The entity meets the requirements of subsection (c)(1)(D) with respect to members enrolled with the organization under this part.

"(E) FISCAL SOUNDNESS; PROVISION AGAINST INSOLVENCY.—The entity meets requirements for fiscal soundness and provision against insolvency developed by the Secretary.

"(2) DETERMINATION OF PRIVATE MEMBERSHIP.—In applying the provisions of sections 1851E(g) and 1851F (e)(1)(B)(i) and (f)(1)(B)(i) (concerning minimum private enrollment) to an organization that meets the requirements of paragraph (1), individuals for whom the organization has assumed substantial financial risk shall be considered to be members of the organization.

"(3) PREEMPTION OF STATE LICENSURE REQUIREMENTS.—Except as otherwise provided in the next sentence, an organization that meets the requirements of paragraph (1) may provide health benefits to individuals enrolled with the organization under this part without regard to any State law that imposes requirements for licensure different from the requirements for a contract under this part. If the Secretary determines that a State has met the criteria for participation in the alternative certification and monitoring program described in section 1851H(b), the Secretary shall require the organization to obtain a license from the State.

"SEC. 1851B. ENROLLMENT AND DISENROLLMENT.

''(a) IN GENERAL.—

''(1) SECRETARY'S RESPONSIBILITY.—The Secretary shall carry out enrollment and termination of enrollment of individuals with eligible organizations.

''(2) INDIVIDUAL OPTIONS.—An individual may, as prescribed by regulations—

''(A) enroll under this part with an eligible organization; and

''(B) terminate enrollment with such organization—

''(i) as of the beginning of the first calendar month following the date on which the request is made for such termination;

''(ii) as of the date determined in accordance with regulations, in the case of financial insolvency of the organization; and

''(iii) retroactively to the date of enrollment, in such special circumstances as the Secretary may designate.

''(b) INFORMATION CONCERNING ENROLLMENT.—

''(1) STANDARDIZED COMPARATIVE MATERIALS.—The Secretary shall develop and distribute standardized comparative materials about eligible organizations and Medicare supplemental policies (as

defined in section 1882(g)(1)) to enable individuals to compare benefits, costs, and quality indicators.

''(2) COST-SHARING BY PARTICIPATING ORGANIZATIONS.—Each eligible organization with a contract under this part shall pay the Secretary for its pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out the requirements of paragraph (1), subsection (a)(1), and section 4360 of OBRA–1990. Those payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

''(3) REVIEW OF MARKETING MATERIALS.—The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may furnish information about the organization to enrollees and individuals eligible to enroll under this part. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) such individuals unless at least 45 days before its distribution, the organization has submitted the material to the Secretary for review, and the Secretary has not disapproved the distribution of the material.

The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(c) PERIODS OF ENROLLMENT.—

''(1) STANDARD ENROLLMENT OPPORTUNITIES.—Subject to the provisions of this section, an organization with a contract under this part shall permit enrollment under this part by any individual—

''(A) during the month of each year specified by the Secretary for all eligible organizations;

''(B) during the individual's initial enrollment period in the program under part B (as described in section 1837(d));

''(C) during a special enrollment period in the program under part B (for individuals formerly electing employment-based coverage) described in section 1837(i)(3); and

''(D) during the 90-day period beginning 30 days before the date the individual takes up residence in the service area of the organization.

''(2) SPECIAL ENROLLMENT PERIOD FOR INDIVIDUALS LOSING COVERAGE BY ANOTHER ORGANIZATION.—

''(A) IN GENERAL.—Subject to other provisions of this section, if a contract with an organization under this part is not renewed or otherwise terminated, or is renewed in a manner that discontinues coverage for individuals residing in part of the service area, each other organization with a contract under this part shall permit enrollment under this part by affected individuals enrolled with such other organization on the effective date of such termination or discontinuation of coverage.

''(B) ENROLLMENT PERIOD.—The enrollment period required by subparagraph (A) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

''(3) ACCEPTANCE OR DENIAL OF APPLICATION.—An eligible organization shall enroll individuals under this part in the order of application, and may deny enrollment of such an individual only if the enrollment—

"(A) would exceed the limits of the organization's capacity (as determined by the Secretary);

"(B) would result in an enrolled population substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization; or

"(C) would result in the organization's failing to meet the requirements of sections 1851E(g) and 1851F (e)(1)(B)(i) and (f)(1)(B)(i) (concerning minimum private enrollment).

"(4) EFFECTIVE DATE OF ENROLLMENT.—An individual's enrollment with an eligible organization under this part shall be effective—

"(A) in the case of an enrollment under paragraph (1)(A), on the first day of the third month beginning after the end of the enrollment period;

"(B) in the case of an enrollment under paragraph (1)(B), as specified by section 1838(a);

"(C) in the case of an enrollment under paragraph (1)(C), as specified by section 1838(e);

"(D) in the case of an enrollment under paragraph (1)(D), on the first day of the first month following the month in which the individual enrolled; and

"(E) in the case of an enrollment under paragraph (2), 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

"(d) ENROLLMENT OR TERMINATION FOR HEALTH REASONS PROHIBITED.—An eligible organization—

"(1) shall not refuse to enroll, and shall not expel or refuse to reenroll, any individual eligible to enroll or enrolled with the organization under this part because of the individual's health status or requirements for health care services;

"(2) shall include in any marketing materials a statement of the requirements of paragraph (1); and

"(3) shall notify each such individual of the requirements of paragraph (1) at the time of the individual's enrollment.

"SEC. 1851C. BENEFITS.

"(a) BASIC BENEFITS.—

"(1) IN GENERAL.—An eligible organization must provide to members enrolled under this part, either directly or through providers and other persons that meet the applicable requirements of this title and part A of title XI—

"(A) those services (other than hospice care) covered under parts A and B of this title, for those members entitled to benefits under part A and enrolled under part B, or

"(B) those services covered under part B, for those members enrolled only under such part,

which are available to individuals residing in the geographic area served by the organization.

"(2) PPO REQUIRED TO AFFORD 'POINT OF SERVICE' OPTION.—An eligible organization that contracts as a preferred provider organization under this part, in addition to providing services in accordance with paragraph (1), shall also pay for any service (other than hospice care) furnished to a member enrolled under this part (in the amounts, if any, that otherwise would be paid under this title) by any entity that may furnish that service under this title (other than an entity through which the organization

provides services, or other than a service with respect to which the organization is required to provide for reimbursement under subsection (e)(2) (concerning urgently needed services provided outside the organization).

''(3) PSO PROHIBITED FROM AFFORDING 'POINT OF SERVICE' OPTION.—An eligible organization that contracts as a provider sponsored organization under this part may not pay for any service described in paragraph (2) that is furnished to a member enrolled under this part.

''(b) ADDITIONAL BENEFITS OR OTHER ADJUSTMENT UNDER RISK PLANS.—

''(1) REQUIREMENT WHERE ADJUSTED COMMUNITY RATES BELOW PAYMENT RATES.—Each contract under section 1851F(e) shall provide for adjustment in accordance with this subsection, if—

''(A) the adjusted community rate for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this part with the organization and entitled to benefits under part A and enrolled in part B, or

"(B) the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this part with the organization and entitled to benefits under part B only,

is less than the average of the per capita rates of payment to be made under section 1851F(e)(2) at the beginning of an annual contract period for members enrolled under this part with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively.

"(2) SELECTION BY ORGANIZATION OF ADDITIONAL BENEFITS.—An eligible organization to which paragraph (1) applies shall either—

"(A) provide to members described in paragraph (1) (A) or (B), as applicable, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); or

"(B) elect an alternative, in accordance with paragraph (4).

''(3) ADDITIONAL BENEFITS.—The additional benefits referred to in paragraph (2) are—

''(A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this part; or

''(B) the provision of additional health benefits; or both.

''(4) ALTERNATIVES TO ADDITIONAL BENEFITS.—An eligible organization to which paragraph (1) applies—

''(A) may elect to receive a lesser payment such that there is no longer a difference between the average of the per capita rates of payment to be made under section 1851F(e)(2) and the adjusted community rate (as so reduced); and

''(B) may (with the approval of the Secretary) provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5).

''(5) BENEFIT STABILIZATION FUND.—An organization having a contract under section 1851(e) may (with the approval of the Secretary) provide that a part of the value of additional benefits other-

wise required to be provided by reason of paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3). Any of such value of additional benefits which is not provided to members of the organization in accordance with paragraph (3) prior to the end of such period, shall revert for the use of such trust funds.

''(6) DETERMINATION OF PER CAPITA RATES.—If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under section 1851F(e)(2) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

''(c) SUPPLEMENTAL BENEFITS.—

''(1) SUBJECT TO SECRETARY'S APPROVAL.—An eligible organization may provide to individuals

enrolled under this part (without affording such individuals an option to decline such coverage), such additional health care services as the Secretary may approve. The Secretary shall approve any such additional services unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

''(2) AT ENROLLEES' OPTION.—Such an organization may provide to such individuals such additional health care services as such individuals may elect, at their option, to have covered.

''(3) DISCLOSURE OF PREMIUM.—Such an organization shall furnish to such individuals information on the portion of its premium rate or other charges applicable to such supplemental benefits.

''(d) STANDARDIZED PACKAGES OF ADDITIONAL BENEFITS.—Any health care service described in subsection (b) or (c) that is included in a standardized package of benefits specified by the Secretary may be offered only as part of that standardized package.

''(e) AVAILABILITY AND ACCESSIBILITY OF SERVICES.—

''(1) SERVICES PROVIDED THROUGH THE ORGANIZATION.—An eligible organization with a contract

under this part must make the services it has contracted to provide to individuals enrolled with the organization under this part—

"(A) available and accessible to each such individual, within the area served by the organization, with reasonable promptness and in a manner which assures continuity, and

"(B) when medically necessary, available and accessible 24 hours a day and 7 days a week.

"(2) SERVICES PROVIDED OUTSIDE THE ORGANIZATION.—An eligible organization with a contract under this part must provide for reimbursement with respect to services described in paragraph (1) provided to such an individual other than through the organization, if—

"(A) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

"(B) it was not reasonable given the circumstances to obtain the services through the organization.

"SEC. 1851D. LIABILITY OF BENEFICIARY AND THIRD PARTIES.

"(a) LIMITS ON LIABILITY FOR REQUIRED BENEFITS.—

"(1) LIMITATION TO ACTUARIAL VALUE OF FEE-FOR-SERVICE COVERAGE.—Total charges by an eligible organization to individuals enrolled with the organization under this part, with respect to services described in section 1851C(a)—

"(A) shall include no amounts other than the individual's share of premiums, deductibles, coinsurance, and copayments; and

"(B) shall not exceed the actuarial value of the deductibles and coinsurance that would be applicable under this title on the average to such individuals if they were not members of an eligible organization.

"(2) ALTERNATIVE DATA.—If the Secretary finds that adequate data are not available for the determination required under paragraph (1) with respect to an eligible organization, the Secretary may substitute the actuarial value of the deductibles and coinsurance applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this part with the organization, or other appropriate data.

''(b) LIMITS ON PREMIUM FOR SUPPLEMENTAL BENEFITS.—If an eligible organization provides to its members enrolled under this part supplemental benefits in accordance with section 1851C, the sum of—

''(1) the portion of such organization's premium rate charged, with respect to such supplemental benefits, to members enrolled under this part, and

''(2) the deductibles, coinsurance, and copayments charged, with respect to such services to such members,

shall not exceed the adjusted community rate for such services.

''(c) LIMITATION ON AMOUNTS AN OUT-OF-PLAN PHYSICIAN OR OTHER ENTITY MAY COLLECT.—

''(1) IN GENERAL.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with an eligible organization shall accept as payment in full for services that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such payments with respect to an individual entitled to benefits under this title (but not

enrolled with an eligible organization under this part) shall also apply with respect to an individual so enrolled.

''(2) SIMILAR REQUIREMENTS.—For similar requirements applicable to providers of services, see section 1866(a)(1)(O).

''(d) PLAN AS A SECONDARY PAYER.—Notwithstanding any other provision of law, an eligible organization may (in the case of the provision of services for which the Medicare program is a secondary payer under section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, plan, or policy—

''(1) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

''(2) such member to the extent that the member has been paid under such law, plan, or policy for such services.

''SEC. 1851E. BENEFICIARY PROTECTIONS.

''(a) EXPLANATION OF RIGHTS AND RESTRICTIONS.—Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's

rights under this part and other important information, including the following:

''(1) COVERAGE.—The enrollee's rights to benefits from the organization, and benefit limitations, including—

''(A) out-of-area coverage provided by the organization,

''(B) the organization's coverage of emergency services and urgently needed care, and

''(C) the restrictions on payments under this title for services furnished other than by or through the organization.

''(2) TERMINATION OF COVERAGE.—An explanation that—

''(A) the organization may terminate or refuse to renew the contract under this part; and

''(B) termination of such contract could result in termination of enrollment of individuals with the organization.

''(3) PATIENT RIGHTS.—Safeguards on enrollees' rights, including—

''(A) appeal rights of enrollees,

''(B) the right to be informed about various treatment options, and

"(C) the right to decline treatment.

"(4) EMERGENCIES.—The appropriate use of the 911 emergency telephone system in the case of medical emergencies.

"(5) FRAUD AND ABUSE REPORTING.—The processes for reporting potential fraud or abuse.

"(b) NOTIFICATION OF TERMINATION OPTION IN MARKETING MATERIALS.—Each eligible organization with a contract under this part shall include the information required by subsection (a)(2) in any marketing materials described in section 1851B(b)(3) that are distributed by an eligible organization to individuals eligible to enroll under this part with the organization.

"(c) GRIEVANCE MECHANISM.—An eligible organization with a contract under this part must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this part.

"(d) COVERAGE DETERMINATIONS AND APPEALS.—

"(1) DETERMINATION BY ORGANIZATION.—An eligible organization with a contract under this part shall have a procedure for determining whether an individual enrolled with the organization under this

part is entitled to receive a health service described in section 1851C(a) and the amount (if any) that the individual is required to pay for that service, which includes the following elements:

''(A) TIMELY REVIEW.—The organization shall provide for review of a coverage issue within 30 days of a request by such individual, and for reconsideration, where requested, within 60 days after the initial review.

''(B) EXPEDITED REVIEW IN URGENT CASES.—The organization shall have an expedited process for review and reconsideration of a coverage issue in cases in which delayed treatment may place the health of such individual in jeopardy, risk serious impairment of bodily functions, or limit medically appropriate treatment options.

''(2) REVIEW BY EXTERNAL CONTRACTOR.—An individual dissatisfied with a determination under paragraph (1) concerning such individual's coverage under a contract under this part is entitled to a hearing before an independent reviewer designated by the Secretary.

''(3) APPEAL TO SECRETARY.—An individual dissatisfied with a determination under paragraph

(2) concerning such individual's coverage under a contract under this part is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 205(b) and 105(g) as provided in this subparagraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(e) QUALITY ASSURANCE.—

''(1) INTERNAL QUALITY ASSURANCE (IQA) PROGRAM.—

''(A) IN GENERAL.—Subject to subparagraph (B), an eligible organization must have arrangements, established in accordance with

regulations of the Secretary, for an ongoing quality assurance program for health care services provided to individuals enrolled with the organization under this part that—

"(i) focuses on health outcomes; and

"(ii) provides for review by physicians and other health care professionals of the process followed in the provision of such health care services.

"(B) ACCEPTANCE OF ACCREDITATION IN SATISFACTION OF IQA STANDARDS.—If (or to the extent that) an eligible organization has been accredited by an accrediting body whose standards with respect to one or more of the elements of an internal quality assurance program are at least as stringent as such standards pursuant to subparagraph (A), the organization shall be deemed to meet the requirements of such subparagraph (A) with respect to such program elements.

"(2) EXTERNAL QUALITY REVIEW.—

"(A) REQUIREMENTS.—Each contract with an eligible organization under this part shall provide that the organization will maintain an agreement with—

"(i) a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located);

"(ii) an entity selected by the Secretary under section 1154(a)(4)(C); or

"(iii) an independent quality review and improvement organization selected by the organization and approved by the Secretary,

under which the review organization will perform functions under section 1154(a) (4)(B) and (14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

"(B) QUALITY REVIEW AS COVERED SERVICE.—For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the review organization on

behalf of such eligible organization in accordance with a schedule established by the Secretary.

''(C) PAYMENT FROM TRUST FUNDS.—Such payments—

''(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

''(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.

''(f) BENEFICIARY ADVANCE DIRECTIVES CONCERNING MEDICAL TREATMENT.—A contract under this part shall provide that an eligible organization shall meet the

requirements of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

''(g) PRIVATE ENROLLMENT REQUIREMENTS.—

''(1) 50 PERCENT REQUIREMENT.—Subject to section 11205 of the Emergency Medicare Protection Act of 1996, each eligible organization with which the Secretary enters into a contract under this part shall have, for the duration of such contract, an enrolled membership (without consideration of members enrolled in the program under title XIX) at least one-half of which consists of individuals who are entitled to benefits under this title.

''(2) EXCEPTIONS.—The Secretary may modify or waive the requirement imposed by paragraph (1) only in the following circumstances:

''(A) AREA WITH LARGE MEDICARE POPULATION.—If more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title.

''(B) INITIAL PERIOD FOR GOVERNMENTAL CONTRACTOR.—In the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period

of three years beginning on the date the organization first enters into a contract under this part, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title.

''(C) UNDERSERVED RURAL AREA.—If the organization serves an underserved rural area.

''(D) CONTRACTOR WITH GOOD PAST RECORD.—If the organization has had contracts under this part for a total of at least three years, has complied with all applicable requirements during that period, maintains a level of enrollment of individuals not entitled to benefits under this title determined by the Secretary, and complies with any additional monitoring requirements established by the Secretary.

''(E) CONTRACTOR WITH GOOD RECORD IN ANOTHER GEOGRAPHIC AREA.—If—

''(i) the Secretary has not previously entered into a contract with the organization under this part in the same geographic area (or has entered into contracts for a total of three years or less),

"(ii) the organization (or a parent company that controls the organization) has entered into (or subsidiaries of the organization or parent company have entered into) contracts under this part for at least three different geographic areas—

"(I) for which no waiver has been granted under this paragraph and during the course of which there has been compliance with all applicable requirements; or

"(II) for which a waiver has been granted under subparagraph (D);

"(iii) the organization (or parent company) demonstrates to the Secretary a long-term business and financial commitment to the geographic area served by the organization, and the Secretary determines that a waiver is necessary to promote competition in that area; and

"(iv) the organization complies with all applicable requirements and any additional monitoring requirements established by the Secretary.

"(F) OTHER SITUATIONS.—In such situations and under such conditions as the Secretary determines will be in the best interest of individuals entitled to benefits under this title.

"(h) ACCESS TO SPECIALTY CARE AND CASE MANAGEMENT.—Each eligible organization shall ensure that enrollees with chronic illnesses or disabilities and other enrollees as appropriate, shall have access to medically appropriate specialty care and medically appropriate case management.

"(i) RESTRICTIONS ON PHYSICIAN INCENTIVE PLANS.—

"(1) CRITERIA.—Each contract with an eligible organization under this part shall provide that the organization may not operate any physician incentive plan (as defined in paragraph (2)) unless the following requirements are met:

"(A) NO INDUCEMENT TO LIMIT CARE.—No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

"(B) REQUIREMENTS WHERE PHYSICIAN AT FINANCIAL RISK.—If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

"(i) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

"(ii) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

"(C) DISCLOSURE TO SECRETARY.—The organization provides the Secretary with de-

scriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this paragraph.

''(2) DEFINITION OF 'PHYSICIAN INCENTIVE PLAN'.—In this subsection, the term 'physician incentive plan' means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

''(j) ADDITIONAL STANDARDS FOR OTHER MANAGED CARE ORGANIZATIONS.—The Secretary shall establish such additional standards for entities treated as eligible organizations under section 1851A(a)(5) as the Secretary determines appropriate.

''SEC. 1851F. CONTRACTS WITH, AND PAYMENTS TO, PLANS.

''(a) GENERAL RULES ON PAYMENTS TO CONTRACTING ORGANIZATION.—

''(1) PAYMENT TO ORGANIZATION ONLY UNDER CONTRACT.—Payments to an eligible organization under a risk or partial risk contract under this part shall be in lieu of the amounts which (in the absence of the contract) would be otherwise payable, pursu-

ant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this part, except as otherwise provided in this subsection.

''(2) PAYMENT FOR ENROLLED INDIVIDUAL ONLY TO ORGANIZATION WITH CONTRACT.—If an individual is enrolled under this part with an eligible organization, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services (other than hospice care) furnished to the individual, except as otherwise provided in this subsection.

''(3) EXCEPTIONS.—

''(A) FAILURE OF ORGANIZATION TO MAKE PROMPT PAYMENT.—For the exception to paragraph (1) that applies if an eligible organization fails to make prompt payments under the contract, see subsection (d).

''(B) MID-YEAR NATIONAL COVERAGE DETERMINATION.—For the exception to paragraph (1) that applies if the Secretary makes a mid-contract year determination that expands benefits under this title, see subsection (i).

''(C) PATIENT HOSPITALIZED ON DATE OF ENROLLMENT.—For the exception to para-

graphs (1) and (2) that applies in the case of a patient hospitalized on the effective date of enrollment with an organization under this part, see subsection (h).

''(D) MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.—The Secretary may make payments (as otherwise provided under this title) to hospitals for payment adjustments for hospitals serving a disproportionate share of low-income patients, for the indirect costs of medical education, or for direct graduate medical education.

''(E) ENROLLED INDIVIDUAL WHO ELECTS HOSPICE CARE.—For the exception to paragraphs (1) and (2) that applies in the case of an individual who is enrolled under this part with an eligible organization and elects under section 1812(d)(1) to receive hospice care provided by a particular hospice program, see subsection (l).

''(4) PAYMENT FROM TRUST FUNDS.—The payment to an eligible organization under this part of individuals enrolled under this part with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal

Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the per capita payments made under section 1851F(e)(2).

''(b) CONTRACT TERM; RENEWAL; TERMINATION.—

''(1) IN GENERAL.—Each contract under this part shall be for a term of at least one year, as determined by the Secretary, beginning on a date specified in the contract, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term, except as provided in paragraph (2).

''(2) TERMINATION BY SECRETARY FOR CAUSE.—The Secretary may terminate any contract described in paragraph (1) at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as may be provided in regulations), if the Secretary finds that the organization—

"(A) has failed substantially to carry out the contract,

"(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, or

"(C) no longer substantially meets the applicable conditions of this part.

"(c) CONTRACT TERMS AND CONDITIONS.—Each contract under this part shall provide for the following:

"(1) AUDIT, INSPECTIONS, EVALUATIONS.—The contract shall provide that the Secretary, or any person or organization designated by the Secretary—

"(A) shall have the right to inspect or otherwise evaluate—

"(i) the quality, appropriateness, and timeliness of services performed under the contract; and

"(ii) the facilities of the organization when there is reasonable evidence of some need for such inspection; and

"(B) shall have the right to audit and inspect any books and records of the eligible organization that pertain—

"(i) to the ability of the organization to bear the risk of potential financial losses; or

"(ii) to services performed or determinations of amounts payable under the contract.

"(2) NOTICE TO ENROLLEES IN EVENT OF TERMINATION OF CONTRACT.—The contract shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this part with the organization.

"(3) DISCLOSURES.—

"(A) FINANCIAL AND LIABILITY INFORMATION.—The contract shall require the organization to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and with the requirement of section 1301(c)(7) of such Act (relating to liability arrangements to protect members).

"(B) OWNERSHIP AND CONTROL INTERESTS.—The contract shall require the organization to report the information required to be re-

ported by disclosing entities under section 1124 (concerning ownership and control interests).

"(C) LOANS AND OTHER FINANCIAL ARRANGEMENTS.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

"(4) OTHER TERMS AND CONDITIONS.—The contract shall contain such other terms and conditions not inconsistent with this part (including requirements that the organization furnish to the Secretary such information) as the Secretary may find necessary and appropriate.

"(d) PROMPT PAYMENT BY ELIGIBLE ORGANIZATION.—

"(1) REQUIREMENT.—A contract under this part shall require an eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

''(2) SECRETARY'S OPTION TO BYPASS NON-COMPLYING ORGANIZATION.—In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this part under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

''(e) RISK CONTRACTS.—

''(1) IN GENERAL.—

''(A) SECRETARY'S AUTHORITY TO CONTRACT.—The Secretary may enter into a risk contract under this subsection (under which payment by the Secretary for covered services to individuals eligible for benefits under this title is based on the per capita rate determined annually under paragraph (2)) with any eligible

organization meeting the requirements of subparagraph (B).

''(B) REQUIREMENTS APPLICABLE TO CONTRACTING ORGANIZATIONS.—An eligible organization qualified to enter a contract under this subsection must meet the following requirements:

''(i) MINIMUM PRIVATE ENROLLMENT.—The organization must have at least 5,000 members not eligible for benefits under this title or title XIX, except that the Secretary may enter into such a contract with an eligible organization that has fewer such members—

''(I) if the organization primarily serves members residing outside of urbanized areas, or

''(II) in such situations and under such conditions as the Secretary determines will be in the best interests of individuals entitled to benefits under this title.

''(ii) ABILITY TO BEAR RISK.—The organization must satisfy the Secretary that it has the ability to bear the risk of

potential losses under a risk contract under this subsection.

''(2) PAYMENTS.—

''(A) MONTHLY PAYMENTS.—Under a contract under paragraph (1), the Secretary shall make monthly payments in advance to each eligible organization, with respect to each individual enrolled under this part with the organization in a payment area for a month, in an amount equal to one-twelfth of the annual capitation rate (as calculated under paragraph (4)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, ESRD status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, or modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

''(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

''(i) IN GENERAL.—The amount of payment under this paragraph may be retroactively adjusted to take into account

any difference between the actual number of individuals enrolled with the organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(ii) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period (not to exceed 90 days) beginning on the date on which the individual enrolls with an eligible organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part.

''(II) EXCEPTION.—No adjustment may be made under subclause

(I) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1851E(a) at the time the individual enrolled with the organization.

''(3) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

''(A) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than August 1 before the calendar year concerned—

''(i) the annual capitation rate for each payment area for the year;

''(ii) the risk and other factors to be used in adjusting the rates under paragraph (2)(A) for payments for months in that year;

''(iii) any adjustments to be made to offset favorable selection under paragraph (4)(F);

''(iv) any adjustments for national coverage determinations under paragraph (4)(G); and

"(v) any adjustment made to the blended payment rate under paragraph (4)(E).

"(B) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide eligible organizations an opportunity to comment on the proposed changes.

"(C) EXPLANATION OF ASSUMPTIONS.—In each announcement made under subparagraph (A) for a year, the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute monthly adjusted capitation rates for individuals in each payment area.

"(4) CALCULATION OF ANNUAL CAPITATION RATES.—

"(A) IN GENERAL.—The annual capitation rate for a payment area for a calendar year is

equal to the greatest of the following (adjusted as provided by subparagraphs (F) through (H)):

"(i) BLENDED CAPITATION RATE.—The sum of—

"(I) the area-specific percentage (as specified under subparagraph (B) for the year) of the area-specific capitation rate for the year for the payment area, as determined under subparagraph (C), and

"(II) the national percentage (as specified under subparagraph (B) for the year) of the input-price-adjusted national capitation rate for the year, as determined under subparagraph (D),

multiplied by a budget neutrality factor adjustment factor determined under subparagraph (E).

"(ii) MINIMUM AMOUNT.—

"(I) for 1997, $325; and

"(II) for a subsequent year, the amount determined under this clause for the preceding year increased by

the national average per capital growth percentage, as specified under subparagraph (I) for that succeeding year.

"(iii) MINIMUM INCREASE OVER PREVIOUS YEAR'S RATE.—

"(I) for 1997, 102 percent of the annual per capita rate of payment for 1996 determined under section 1876(a)(1)(C) for the payment area; and

"(II) for a subsequent year, 102 percent of the annual capitation rate under this paragraph for the preceding year for the payment area.

"(B) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of subparagraph (A)(i)—

"(i) for 1997, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent,

"(ii) for 1998, the 'area-specific percentage' is 85 percent and the 'national percentage' is 15 percent,

"(iii) for 1999, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

"(iv) for 2000, the 'area-specific percentage' is 75 percent and the 'national percentage' is 25 percent, and

"(v) for a year after 2000, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent.

"(C) AREA-SPECIFIC CAPITATION RATE.—

"(i) IN GENERAL.—For purposes of subparagraph (A)(i)(I), subject to clause (ii) of this subparagraph, the area-specific capitation rate for a payment area—

"(I) for 1997 is the annual per capita rate of payment for 1996 determined under section 1876(a)(1)(C) for the payment area, increased by the national average per capita growth percentage for 1997 (as specified in subparagraph (I)), and

"(II) for a subsequent year is the area-specific capitation rate for the previous year for the payment area,

increased by that percentage for that subsequent year.

''(ii) REMOVAL OF MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—In determining the area-specific capitation rate under clause (i)(II) for 1998 and for subsequent years, the area-specific capitation rate for 1997 determined under clause (i)(I) shall be adjusted to exclude from that rate any amount which the Secretary estimates was payable under this title during 1996 for payment adjustments under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients, for the indirect costs of medical education under section 1886(d)(5)(B), or for direct graduate medical education costs under section 1886(h).

''(D) INPUT-PRICE-ADJUSTED NATIONAL CAPITATION RATE.—

''(i) IN GENERAL.—For purposes of subparagraph (A)(i)(II), the 'input-price-

adjusted national capitation rate' for a year for a payment area is equal to the sum, for all the types of services under this title (as classified by the Secretary), of the product (for each such type) of—

"(I) the national standardized capitation rate (determined under clause (ii)) for the year,

"(II) the proportion of that rate for the year that is attributable to that type of services, and

"(III) an index that reflects (for that year and that type of services) the relative input price of the services in the area compared with the national input price of the services.

In applying subclause (III), the Secretary shall, subject to clause (iii), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

"(ii) NATIONAL STANDARDIZED CAPITATION RATE.—In clause (i)(I), the 'national standardized capitation rate' for a year is equal to—

''(I) the sum (for all payment areas) of the product of the area-specific capitation rate for the year for the area under subparagraph (C) and the average number of individuals entitled to benefits under this title who reside in that area in the year, divided by

''(II) the total average number of individuals entitled to benefits under this title who reside in all payment areas in the year.

''(iii) SPECIAL RULES FOR 1997 AND 1998.—In applying this subparagraph for 1997—

''(I) services under this title shall be divided into services under part A and services under part B,

''(II) the proportions described in clause (i)(II) for such types of services shall be, for services under part A, the ratio (expressed as a percentage) of the average annual per capita rate of payment for the area for part A for 1995 to the total average annual per

capita rate of payment for the area for parts A and B, and, for services under part B, 100 percent minus the percentage described for services under part A,

''(III) for services under part A, 70 percent of payments attributable to those services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved,

''(IV) for services under part B, 66 percent of payment attributable to those services shall be adjusted by the index of the geographic area factors used under section 1848(e) to adjust payment rates for physicians' services furnished in the payment area, and 70 percent of the remaining 34 percent shall be adjusted by the index described in subclause (III), and

''(V) the index values shall be computed based only on the popu-

lation of individuals entitled to benefits under this title who are 65 years of age or older and who have not been determined to have end-stage renal disease.

The Secretary may continue to apply the rules described in the preceding subclauses (or similar rules) in 1998.

''(E) BUDGET NEUTRALITY ADJUSTMENT FACTOR.—For each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if the area-specific percentage for the year had been 100 percent and the national percentage had been 0 percent.

''(F) ADJUSTMENT TO OFFSET COST OF FAVORABLE SELECTION.—For each year, the Secretary shall determine the adjustment, if any, needed to offset any estimated increases in total projected expenditures under this title resulting from increases in enrollment in eligible organizations attributable to enactment of this part.

"(G) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS.—If the Secretary makes a determination with respect to coverage under this title that the Secretary projects will result in a significant increase in the costs to eligible organizations of providing benefits under contracts under this part (for periods after any period described in subsection (i)), the Secretary shall make an appropriate adjustment in the payments to eligible organizations under this part.

"(H) ADJUSTMENT TO REMOVE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM 1997 RATES.—Annual capitation rates for 1997 shall be adjusted to exclude from that rate any amount which the Secretary estimates were payable under this title during 1996 for payment adjustments under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients, for the indirect costs of medical education under section 1886(d)(5)(B), or for direct graduate medical education costs under section 1886(h).

"(I) NATIONAL AVERAGE PER CAPITA GROWTH PERCENTAGE.—For purposes of subparagraphs (A)(ii)(II) and (C)(i)(I), the 'national average per capita growth percentage' shall be the percentage determined by the Secretary on an annual basis (not later than August 1 before the year concerned) to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title.

"(5) PAYMENT AREA DEFINED.—

"(A) IN GENERAL.—For purposes of this part, except as provided by subparagraph (B), the term 'payment area' means a county, or equivalent area specified by the Secretary.

"(B) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end-stage renal disease, the payment area shall be a State or other area specified by the Secretary.

"(f) PARTIAL RISK CONTRACTS.—

"(1) IN GENERAL.—

"(A) SECRETARY'S AUTHORITY TO CONTRACT.—The Secretary may enter into a partial risk contract under this subsection (under which payment by the Secretary for covered

services to individuals eligible for benefits under this title shall be made as provided in paragraph (2)) with any eligible organization meeting the requirements of subparagraph (B).

''(B) REQUIREMENTS APPLICABLE TO CONTRACTING ORGANIZATIONS.—An eligible organization qualified to enter a contract under this subsection must meet the following requirements:

''(i) MINIMUM PRIVATE ENROLLMENT.—The organization must have at least 1,500 members not entitled to benefits under this title or title XIX, except in such situations and under such conditions as the Secretary determines will be in the best interests of individuals entitled to benefits under this title.

''(ii) ABILITY TO BEAR RISK.—The organization must satisfy the Secretary that it has the ability to bear the risk of potential losses under a partial risk contract under this subsection.

''(2) PAYMENTS.—The Secretary shall make payments to an organization with a partial risk con-

tract under this subsection, for services provided under such contract, as follows:

"(A) INTERIM MONTHLY PAYMENTS.—The Secretary shall make payments over a 12-month period in amounts equal to 95 percent of modified fee for service amounts (as defined in paragraph (4)).

"(B) FINAL RETROSPECTIVE ADJUSTMENT.—After the end of such 12-month period, the Secretary shall make a final payment adjustment, as follows:

"(i) IF PLAN COSTS ARE BELOW TOTAL ANNUAL CAPITATION PAYMENTS.—If 100 percent of the modified fee for service amounts paid under subparagraph (A) for that period were less than total annual capitation payments (as defined in paragraph (4)), the Secretary shall pay the organization (in addition to the amounts paid under subparagraph (A)) 5 percent of modified fee for service amounts, plus one-half of the difference between the total annual capitation payments and 100 percent of the modified fee for service amounts paid under subparagraph (A).

"(ii) IF PLAN COSTS ARE BETWEEN THE TOTAL ANNUAL CAPITATION PAYMENTS AND 110 PERCENT OF SUCH PAYMENTS.—If 100 percent of the modified fee for service amounts paid made under subparagraph (A) equal to or greater than total annual capitation payments, but not more than 110 percent of such amount, the Secretary shall pay the organization an additional amount (in addition to the amounts paid under subparagraph (A)) such that the total amounts paid the organization equal the sum of the total annual capitation payments plus one-half of the difference between 100 percent of the modified fee for service amounts and total annual capitation payments.

"(iii) IF PLAN COSTS ARE GREATER THAN 110 PERCENT OF TOTAL ANNUAL CAPITATION PAYMENTS.—If 100 percent of the modified fee for service amounts paid under subparagraph (A) exceeded 110 percent of total annual capitation payments, the Secretary shall pay the organization, or the organization shall refund to the Sec-

retary, an amount such that the total amounts paid the organization equal 105 percent of total annual capitation payments.

"(3) NONRENEWAL FOR EXCESSIVE COSTS.—If paragraph (2)(B)(iii) applies two years in succession, the contract shall not be renewed.

"(4) DEFINITIONS.—

"(A) MODIFIED FEE FOR SERVICE AMOUNTS.—For purposes of this subsection, 'modified fee for service amounts' are the amounts that the Secretary would have paid under this title (other than under this part) excluding payment adjustments under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients, for the indirect costs of medical education under section 1886(d)(5)(B), or for direct graduate medical education costs under section 1886(h).

"(B) TOTAL ANNUAL CAPITATION PAYMENTS.—For purposes of this subsection, 'total annual capitation payments' are equal to the total payments that the eligible organization would have received for the year if it had a con-

tract under subsection (e) instead of under this subsection.

"(g) MINIMUM PERIOD OF NONPARTICIPATION AFTER CONTRACT TERMINATION.—

"(1) IN GENERAL.—The Secretary may not enter into a contract with an eligible organization under this part, except in circumstances (as determined by the Secretary) which warrant special consideration, if a previous contract with that organization was terminated within the preceding five-year period—

"(A) at the request of the organization; or

"(B) pursuant to subsection (f)(3), for excessive costs under a partial risk contract.

"(2) INAPPLICABILITY TO CONTRACT CONVERSIONS.—For purposes of the requirement of paragraph (1), a conversion from a risk to a partial risk contract shall not be considered a contract termination.

"(h) SPECIAL RULE FOR HOSPITALIZED PATIENTS.—A contract under this part shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) enrollment with an eligible organization under this part—

''(A) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

''(B) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

''(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part, or

''(2) termination of enrollment with an eligible organization under this part—

''(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

''(B) payment for such services during the stay shall not be made under section 1886(d), and

''(C) the organization shall not receive any payment with respect to the individual under

this part during the period the individual is not enrolled.

''(i) SPECIAL RULE FOR NATIONAL COVERAGE DETERMINATION.—

''(1) If the Secretary makes a determination with respect to coverage under this title that the Secretary projects will result in a significant increase in the costs to eligible organizations of providing benefits under contracts under this part—

''(A) during an annual contract period under a risk contract; or

''(B) during a 12-month payment period under a partial risk contract,

the provisions of this subsection apply to benefits and payments during the remainder of the term of such contract.

''(2) COVERAGE OF EXPANDED BENEFITS.—The organization shall be required to provide (or arrange for provision of) the expanded benefit to individuals enrolled under this part as of the date such benefit would have been available to them had they not been so enrolled.

''(3) PAYMENT FOR EXPANDED BENEFITS.—If (or to the extent) the increased costs attributable to the expanded benefits were not taken into account in

establishing per capita payment rates under a risk contract, or in determining the total annual capitation payments applicable to a partial risk contract—

"(A) in the case of an organization with a risk contract, the Secretary shall make an additional payment for the provision of such expanded benefits during such remaining portion of the contract term, notwithstanding any other provision of this part, equal to the amount that the Secretary would have paid under this title (other than under this part); and

"(B) in the case of an organization with a partial risk contract, the applicable total annual capitation payments shall be recalculated to take the increased costs of such expanded benefits into account for such remaining portion of the contract term.

"(j) GENERAL PROVISIONS.—

"(1) GENERAL AUTHORITY OF SECRETARY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine

to be inconsistent with the furtherance of the purpose of this title.

''(2) SERVICE AREA.—The Secretary may prescribe criteria for the geographic area to be served by an eligible organization. The criteria may vary for different kinds of eligible organizations.

''(k) USER FEES.—

''(1) FEE FOR CERTIFICATION.—Each entity requesting to be certified as an eligible organization shall pay the Secretary for the estimated costs to be incurred by the Secretary for certification activities.

''(2) FEE FOR MONITORING ACTIVITIES.—Eligible organizations with a contract under this part shall pay the Secretary for the estimated costs to be incurred by the Secretary for monitoring activities.

''(3) AUTHORIZATION.—The payments described in paragraphs (1) and (2) are appropriated to defray the cost described in such paragraphs, to remain available until expended.

''(l) SPECIAL RULE FOR HOSPICE CARE.—

''(1) INFORMATION.—A contract under this part shall require the organization to inform each individual enrolled under this part with the organization about the availability of hospice care if—

"(A) a hospice participating under this title is located within the organization's geographic area; or

"(B) it is common practice to refer patients to hospices outside the geographic area.

"(2) PAYMENT.—If an individual who is enrolled with an eligible organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice—

"(A) payment for the hospice care services furnished to the individual shall be made by the Secretary for the hospices elected by the individual; and

"(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the eligible organization or the provider or supplier of the service in lieu of payments calculated under subsections (e) and (f).

"SEC. 1851G. SANCTIONS.

"(a) VIOLATIONS SUBJECT TO CIVIL MONEY PENALTIES.—In addition to any other remedies authorized by

law, the Secretary may impose a civil money penalty in accordance with subsection (c) on an eligible organization with a contract under this part that has committed any of the following violations.

''(1) FAILURE TO PROVIDE MEDICALLY NECESSARY CARE.—The organization has failed substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual.

''(2) EXCESSIVE PREMIUMS.—The organization has imposed premiums on individuals enrolled under this part in excess of the premiums permitted.

''(3) DISCONTINUATION OF COVERAGE.—The organization has expelled or refused to reenroll an individual in violation of the provisions of this part.

''(4) DISCOURAGING ENROLLMENT.—The organization has engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services.

''(5) FALSE INFORMATION.—The organization has misrepresented or falsified information furnished—

''(A) to the Secretary under this part, or

''(B) to an individual or to any other entity under this part.

''(6) FAILURE TO COOPERATE WITH EXTERNAL QUALITY REVIEW.—The organization fails to cooperate in the performance of the review required under section 1851E(e)(2).

''(7) PHYSICIAN INCENTIVE PLAN VIOLATIONS.—The organization fails to comply with the requirements of section 1851E(i).

''(8) RELATIONSHIP WITH EXCLUDED INDIVIDUAL OR ENTITY.—The organization—

''(A) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services; or

''(B) employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

''(b) VIOLATIONS SUBJECT TO INTERMEDIATE SANCTIONS.—In addition to any other remedies authorized by law, the Secretary may impose an intermediate sanction in accordance with subsection (d) on an eligible organization with a contract under this part that has committed any of the following violations:

''(1) VIOLATION SUBJECT TO CIVIL MONEY PENALTY.—Any violation specified in subsection (a).

''(2) GROUNDS FOR TERMINATION OF CONTRACT.—Any violation that would be grounds for termination of the contract with the organization pursuant to section 1851F(b)(2).

''(3) FAILURE TO MAKE PROMPT PAYMENT.—Failure to make prompt payment as required by section 1851F(d).

''(4) DELAYED COVERAGE DETERMINATIONS.—Failure to meet timeliness standards for coverage determinations under section 1851E(d)(1).

''(5) INSUFFICIENT PRIVATE ENROLLMENT.—Failure to meet the minimum requirements of section 1851E(g).

''(c) CIVIL MONEY PENALTIES.—

''(1) AMOUNT OF PENALTY.—The Secretary may impose, on an eligible organization determined to have committed a violation specified in subsection

(a), civil money penalties not to exceed the sum of the following amounts, as applicable:

"(A) For each such determination, not more than—

"(i) $100,000, in the case of a determination under subsection (a) (4) or (5)(A); or

"(ii) $25,000, in the case of any other such determination.

"(B) With respect to a determination under subsection (a)(2), double the excess amount charged (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

"(C) With respect to a determination under subsection (a)(4), $15,000 for each individual not enrolled as a result of the practice involved.

"(2) ADMINISTRATIVE PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) shall apply to a civil money penalty under this section in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(d) INTERMEDIATE SANCTIONS.—The Secretary may impose, on an eligible organization determined to have committed a violation specified in subsection (a) or (b), either or both of the following sanctions.

''(1) SUSPENSION OF ENROLLMENT.—Suspension of enrollment of individuals with the organization under this part after the date the Secretary notifies the organization of a determination under subsection (a) or (b) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(2) SUSPENSION OF PAYMENT.—Suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under subsection (a) or (b) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''SEC. 1851H. ALTERNATIVE CERTIFICATION AND MONITORING PROGRAM.

''(a) IN GENERAL.—The Secretary shall develop a program under which States using Federal standards could certify entities as eligible organizations and assist in monitoring eligible organizations with contracts under section 1851F.

''(b) CRITERIA FOR STATE PARTICIPATION.—States can participate in the program described in subsection (a) if upon the request of a State the Secretary determines that—

''(1) the State's standards are substantially equivalent to Federal standards for certification as an eligible organization;

''(2) the State has the ability and sufficient resources to carry out the certification function to the Secretary's satisfaction; and

''(3) the State has the ability and sufficient resources to carry out the monitoring function to the Secretary's satisfaction.

''(c) FEDERAL ROLE AFTER APPROVAL OF STATE PROGRAM.—

''(1) 'LOOK-BEHIND' FUNCTION.—The Secretary will periodically review the performance of State programs under this section to ensure continued compliance with the requirements under subsection (b). Such review program shall include review of a sample of plans certified in each State.

''(2) FEDERAL ADMINISTRATIVE AND OVERSIGHT ACTIVITIES.—In developing the program under this section, the Secretary would retain, at a minimum, responsibility for enrollment and

disenrollment of Medicare beneficiaries, payment to plans, approval of adjusted community rate (ACR) proposals and supplemental benefits, approval of Medicare marketing material, development of comparative materials, monitoring resolution of complaints, administering the Medicare reconsideration and appeals process, reviewing and approving requests for waivers of the 50/50 and minimum enrollment requirements, and managing the external quality review program.

''(3) ENFORCEMENT ACTIVITIES.—The Secretary will determine the appropriate sanctions or contract actions against plans that are out of compliance with standards.

''(4) CONTRACTING AUTHORITY.—In general, once a State has certified an entity as an eligible organization, the entity is eligible for a contract under section 1851F. However, the Secretary can deny a contract to an otherwise eligible organization if the Secretary determines either that the organization cannot bear the level of risk required under the contract, or that the organization is not otherwise able to administer a contract effectively.

''(d) USE OF MORE STRINGENT STANDARDS.—Beginning in 1999, States participating in the program de-

scribed in this section could impose more stringent requirements in certifying eligible organizations and in monitoring eligible organizations with contracts under section 1851F, if such requirements—

''(1) have been approved by the Secretary, and

''(2) are imposed on health plans in a nondiscriminatory manner.

''SEC. 1851I. DEFINITIONS.

''(a) ADJUSTED COMMUNITY RATE.—

''(1) IN GENERAL.—For purposes of this part, the term 'adjusted community rate' for a service or services means, at the election of an eligible organization, either—

''(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this part with an eligible organization if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

''(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this part with the eligible organization,

as the Secretary annually estimates is attributable to that service or services,

adjusted in accordance with paragraph (2).

''(2) ADJUSTMENT OF DIFFERENCES IN UTILIZATION.—The rate determined in accordance with subparagraphs (A) and (B) of paragraph (1) shall be adjusted for—

''(A) the differences between the utilization characteristics of the members enrolled with the eligible organization under this part and the utilization characteristics of the other members of the organization; or

''(B) (if the Secretary finds that adequate data are not available to calculate the adjustment pursuant to subparagraph (A)) the differences between—

''(i) the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this part with an eligible organization, and

''(ii) the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively.

''(b) ADJUSTED AVERAGE PER CAPITA COST (AAPCC).—For purposes of this part, the term 'AAPCC' (adjusted average per capita cost) means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1861(s)(2)(H), if the services were to be furnished by a physician or as an incident to a physician's service.''.

(b) REPEAL OF SUPERSEDED PROVISION.—Section 1876 (42 U.S.C. 1395mm) is repealed, except to the extent provided in subsection (e).

(c) CONFORMING AMENDMENTS.—

(1) Section 1154(a)(4)(B) (42 U.S.C. 1320c–3(a)(4)(B)) is amended—

(A) in the first sentence, by striking ''risk-sharing contract under section 1876'' and inserting ''contract under part C of title XVIII'', and

(B) in the second sentence, by striking ''a health maintenance organization or competitive medical plan under section 1876'' and inserting ''an eligible organization under part C of title XVIII''.

(2) The second sentence of section 1154(a)(4)(C) (42 U.S.C. 1320c–3(a)(4)(C)) is amended by striking ''section 1876'' and inserting ''part C of title XVIII''.

(3) Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended by striking ''risk-sharing contract under section 1876'' and inserting ''contract under part C''.

(4) The matter in the first sentence of section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) preceding subparagraph (A) is amended by striking ''1876(c)(8)'' and inserting ''1851E(f)''.

(5) Section 1866(f)(2)(E) (42 U.S.C. 1395cc(f)(2)(E)) is amended by striking ''1876(b)'' and inserting ''1851A(a)''.

(6) Section 1882(g)(1) (42 U.S.C. 1399ss(g)(1)) is amended—

(A) by striking ''1876(b)'' and inserting ''1851A''; and

(B) by striking ''section 1876'' and inserting ''part C''.

(d) EFFECTIVE DATE.—Except to the extent otherwise provided, the amendments made by the preceding subsections apply to items and services furnished after 1996.

(e) TRANSITION PROVISIONS FOR COST CONTRACTS.—

(1) REPEAL OF AUTHORITY FOR COST CONTRACTS DELAYED TO 2001.—The amendments made by the preceding subsections (other than the amendments specified in paragraph (2)) do not apply to items and services furnished before 2001 under a contract under section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)).

(2) PROVISIONS WHOSE EFFECT IS NOT DELAYED.—The effective dates of the following provisions of part C of the Social Security Act (as added by subsection (a)(2) of this section) shall not be delayed by reason of paragraph (1):

(A) DEFINITION OF QUALIFIED HMO.—Section 1851A(b).

(B) ENROLLMENT AND DISENROLLMENT.—Section 1851B.

(C) BENEFICIARY PROTECTIONS.—Subsections (a) (explanation of patients' rights and restrictions), (c) (grievance mechanism), (d) (coverage determinations and appeals), and (g) (private enrollment requirements) of section 1851E.

(3) OPTION RESTRICTED TO GRANDFATHERED ORGANIZATIONS.—With respect to services provided after 1996 but before 2001, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may enter into contracts under subsection (h) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) only with entities with which the Secretary has entered into contracts under that subsection for all or part of 1996, or to which payments have been made during 1996 under section 1833(a)(1)(A) of such Act (42 U.S.C. 1395l(a)(1)(A)).

(f) REGULATIONS.—

(1) CONTINUITY OF CURRENT REGULATIONS.—Regulations in effect (or available in proposed form)

on December 31, 1996, that apply to section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall apply to part C of title XVIII of that Act (as added by subsection (a)(2)), except to the extent that the regulations are inconsistent with the provisions of that part.

(2) INTERIM FINAL REGULATIONS.—The Secretary may issue regulations before 1998 for part C of title XVIII of the Social Security Act (as added by subsection (a)(2)) on an interim final basis.

(g) CONSIDERATION OF EXPERIENCE UNDER SECTION 1876 IN SATISFACTION OF REQUIREMENTS OF PART C.—Any requirement in part C of title XVIII of the Social Security Act (as added by subsection (a)(2)) that (in a particular context) relates to matters that occurred before 1997 shall be satisfied if the corresponding requirement was satisfied under section 1876 (42 U.S.C. 1395mm) of such Act.

(h) ENROLLMENT TRANSITION RULE.—An individual who is enrolled on December 31, 1996, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1997, under part C of title XVIII of that Act (as added by subsection (a)(2)) if that organization has a contract under such part

for providing services on January 1, 1997 (unless the individual has disenrolled effective on that date).

(i) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1851B(b)(2) of the Social Security Act (as added by subsection (a)(2)) (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations occurring after the date of enactment of this Act.

SEC. 11203. DEVELOPMENT OF FEDERAL STANDARDS.

(a) PUBLISHING REGULATIONS.—By January 1, 1997, the Secretary of Health and Human Services shall develop and promulgate interim final regulations for—

(1) certification standards for eligible organizations under section 1851A(a) (as added by section 11202);

(2) standards for fiscal soundness and requirements concerning adequate protection against the risk of insolvency for provider sponsored organizations seeking certification as an eligible organization;

(3) standards for monitoring eligible organizations with contracts under section 1851F (as added by such section); and

(4) any other standards or procedures required to implement provisions of part C (as added by such section).

(b) CONSULTATION.—In developing the regulations described in subsection (a), the Secretary of Health and Human Services shall consult, among others, with the National Association of Insurance Commissioners, organizations that provide or pay for health care services, and consumer organizations.

SEC. 11204. APPLICABILITY OF MEDICARE RATES TO ENROLLEES WHO USE AN OUT-OF-PLAN PROVIDER OF SERVICES.

(a) IN GENERAL.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking ''in the case of hospitals and skilled nursing facilities,'';

(2) by striking ''inpatient hospital and extended care services that are covered under this title and'' and inserting ''services that''; and

(3) by striking ''(in the case of hospitals) or limits (in the case of skilled nursing facilities)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished after 1996.

SEC. 11205. SUBSTITUTION OF QUALITY MEASUREMENT SYSTEM FOR PRIVATE ENROLLMENT REQUIREMENT.

(a) PROMULGATION OF REGULATIONS.—The Secretary of Health and Human Services, after consulting with representatives from managed health care plans (including representatives of provider service organizations), consumer organizations, and other major purchasers of managed care services shall publish—

(1) proposed regulations by July 1, 1997, requiring the collection, analysis, and reporting of data that will permit measurement of outcomes and other indices of the quality of managed care plans; and

(2) final regulations after completing review of comments on the proposed regulations published pursuant to paragraph (1).

(b) REVISION OF BENEFICIARY PROTECTION REQUIREMENT.—As of the effective date of final regulations published pursuant to subsection (a), section 1851E(g) (as added by section 11202(a)(2) of this Act) is amended to read as follows:

''(g) QUALITY MEASUREMENT SYSTEM.—Each eligible organization with which the Secretary enters into a contract under this part shall meet the requirements of the quality measurement system established by the Secretary in regulations.''.

SEC. 11206. HMO COMPETITIVE PRICING AND RELATED DEMONSTRATIONS.

(a) AMENDMENT EFFECTIVE ON DATE OF ENACTMENT.—Section 402(b) of the Social Security Amendments of 1967 (42 U.S.C. 1395–1(b)) is amended by inserting after the first sentence the following: ''The Secretary may also waive, in the case of such an experiment or demonstration project, compliance with the requirements of sections 1876 and 1882 of that Act.''.

(b) AMENDMENT EFFECTIVE FOR 1997–2000.—

(1) The second sentence of section 402(b) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1(b)) (as added by subsection (a) of this section) is amended by inserting ''and part C of title XVIII'' after ''1882''.

(2) The amendment made by paragraph (1) applies to activities occurring after 1996.

(c) AMENDMENT EFFECTIVE AFTER 2000.—

(1) The second sentence of section 402(b) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1(b)) (as added by subsection (a) and amended by subsection (b) of this section) is further amended by striking ''sections 1876 and 1882'' and inserting ''section 1882''.

(2) The amendment made by paragraph (1) applies to activities occurring after 2000.

(d) RECOMMENDATIONS ON NEW PAYMENT METHODOLOGY.—Not later than January 1, 2002, the Secretary of Health and Human Services shall make recommendations to Congress concerning a new payment methodology for contracts under part C of title XVIII of the Social Security Act, based on the results of competitive pricing or related demonstrations.

SEC. 11207. ELIMINATION OF HEALTH CARE PREPAYMENT PLAN OPTION FOR ENTITIES ELIGIBLE TO PARTICIPATE UNDER PART C.

(a) ELIMINATION OF OPTION.—

(1) IN GENERAL.—Section 1833(a)(1)(A) (42 U.S.C. 1395l(a)(1)(A)) is amended by inserting after ''prepayment basis'' the following: ''(and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to services furnished after 1996.

(b) MEDIGAP AMENDMENT.—Section 1882(g) (42 U.S.C. 1395ss(g)) is amended by striking '', during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995,''.

SEC. 11208. MEDIGAP REFORMS.

(a) UNIFORM ENROLLMENT PERIODS.—

(1) IN GENERAL.—Section 1882(s)(2)(A) (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking ''an application is submitted'' and all that follows and inserting the following: ''an application is submitted—

''(i) prior to or during the 6-month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B;

''(ii) during an annual 30-day period specified by the Secretary; or

''(iii) during a period specified by the Secretary in the circumstances described in section 1851B(c)(2) (with respect to an individual losing coverage through an organization's termination of contract or discontinuation of coverage).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) is effective after 1996.

(b) STANDARDIZED INFORMATION.—

(1) PAYMENTS.—

(A) PRO RATA SHARE.—

(i) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following:

''(u) Each entity that offers a Medicare supplemental policy shall pay the Secretary for its pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out the requirements of the first sentence of section 1851B(b)(1) and section 4360 of the Omnibus Reconciliation Act of 1990. Those payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.''.

(ii) CONFORMING AMENDMENT.—Section 1882(c)(5) (42 U.S.C. 1395ss(c)(5)) is amended by striking ''(t)'' and inserting ''(u)''.

(B) FUNDING.—Section 4360(g) of the Omnibus Reconciliation Act of 1990 (42 U.S.C. 1395b–4(g)) is amended to read as follows:

''(g) FUNDING.—For funding provisions, see section 1851B(b)(2), and section 1882(u), of the Social Security Act.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to demonstrations occurring after the date of enactment of this Act, and to other activities occurring after 1996.

(c) COMMUNITY RATING.—

(1) IN GENERAL.—Section 1882(c) (42 U.S.C. 1395ss(c)) is amended—

(A) by striking ''and'' at the end of paragraph (4),

(B) by striking the period at the end of paragraph (5) and inserting ''; and'', and

(C) by adding after paragraph (5) the following:

''(6) provides for the same premium for each enrollee.''.

(2) CONFORMING AMENDMENT.—Section 1882(b)(1)(B) (42 U.S.C. 1395ss(b)(1)(B)) is amended by striking ''(5)'' and inserting ''(6)''.

(3) EFFECTIVE DATE AND TRANSITIONAL PROVISIONS.—The amendments made by this subsection apply to policies and plans as of the beginning of 1997 (whether issued before or after that time), subject to such transitional rules as the Secretary of Health and Human Services may develop after consulting with the National Association of Insurance Commissioners.

(d) LONG-TERM CARE INSURANCE SAFE HARBOR.—

(1) IN GENERAL.—Section 1882(d)(3)(C) (42 U.S.C. 1395ss(d)(3)(C)) is amended—

(A) by striking ''or (iii)'' and inserting ''(iii)''; and

(B) by inserting before the period the following: '', or (iv) the sale or issuance of a health insurance policy (or rider to an insurance contract which is not a health insurance policy) providing benefits only for long-term care, nursing home care, home health care, or community-based care, or any combination thereof, that coordinates against or excludes items and services available under this title, if such coordination or exclusion is disclosed in the policy's outline of coverage.''.

(2) EFFECTIVE DATE AND OTHER RULES.—

(A) IN GENERAL.—The amendments made by this subsection shall take effect as if included in the enactment of section 4354 of OBRA–1990.

(B) PENALTY.—No penalty shall be imposed under section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) of the Social Security Act for any Act or omission occurring after the effective date of the amendments made by section 4354 of OBRA–1990 and before the date of the enactment of this Act relating to the

sale of a health insurance policy described in section 1882(d)(3)(C)(iv) of the Social Security Act.

SEC. 11209. STANDARDIZED BENEFITS PACKAGES.

(a) MANAGED CARE.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), not later than July 1, 1996, after consulting with the National Association of Insurance Commissioners, consumer groups, managed care plans, providers of health care, and insurers, shall develop standard packages of benefits (in addition to the benefits covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)) that may be offered by eligible organizations under part C of that title (as added by section 11202(a)(2) of this Act).

(b) MEDIGAP.—

(1) EXAMINATION AND RECOMMENDATION.—

(A) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners, in consultation with consumer groups, managed care plans, providers of health care, and insurers, to examine (and recommend by March 1, 1997, any restructuring needed for) the standard benefit packages developed under section 1882(p)(2) of the Social Security Act (42 U.S.C. 1395ss(p)(2)) in order to facili-

tate to the maximum extent feasible comparison across Medicare supplemental policies and benefits offered by eligible organizations under section 1876 of such Act.

(B) RESTRUCTURE.—The Secretary, not later than May 1, 1997, after taking into account any recommendations made under subparagraph (A) by the National Association of Insurance Commissioners, shall restructure, as needed, those standard benefit packages.

(2) AMENDMENTS.—

(A) BENEFITS.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended by adding at the end the following:

''(11) The groups or packages of benefits (including the core group of basic benefits) under paragraph (2) shall be modified by any changes made by the Secretary under section 11209(b)(1)(B) of the Emergency Medicare Protection Act of 1996.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services provided after 1997.

SEC. 11210. ANTITRUST RULE OF REASON STANDARD.

In any action under the antitrust laws (or under any State law similar to the antitrust laws)—

(1) the conduct of an organization that provides health care services in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians) under part C of title XVIII of the Social Security Act (as added by section 11202(a)(2)), and

(2) the conduct of any member of such an organization in carrying out such a contract,

shall not be deemed illegal per se if each member of the organization shares, directly or indirectly, substantial financial risk in connection with the organization's operations.

SEC. 11211. REFORM OF THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988.

(a) REDUCED REQUIREMENTS FOR CERTIFICATES.—Section 353(d)(1) of the Public Health Service Act (42 U.S.C. 263a(d)(1)) is amended—

(1) by striking ''or have its certificate renewed'' in the matter preceding subparagraph (A);

(2) by amending clause (ii) of subparagraph (A) to read as follows:

''(ii) that describes the characteristics of the laboratory examinations and other procedures performed by the laboratory,

including the number and type of laboratory examinations and procedures, and''; and

(3) by adding after subparagraph (E) the following:

''A certificate may be renewed by the Secretary after the Secretary verifies certain essential information in a renewal process established by the Secretary not later than July 1, 1996.''.

(b) ANNOUNCEMENT OF INSPECTIONS.—Section 353(g)(1) of the Public Health Service Act (42 U.S.C. 263a(g)(1)) is amended—

(1) in the first sentence, by striking '', on an announced or unannounced basis,''; and

(2) by adding at the end the following: ''All inspections under this paragraph which are routine shall be announced and inspections under this paragraph which are based on a complaint or other reason to believe a laboratory may not be in compliance with the requirements of subsection (d) or the standards issued under subsection (f) may be unannounced.''.

(c) FLEXIBLE INSPECTIONS OF UNACCREDITED LABORATORIES.—The next to last sentence of section 353(g)(2) of the Public Health Service Act (42 U.S.C.

263a(g)(2)) is amended to read as follows: ''Inspections of laboratories not accredited under subsection (e) shall be conducted with such frequency as the Secretary determines to be necessary to assure compliance with performance-based criteria established by the Secretary not later than January 1, 1997, except that such inspections may not be conducted more frequently than biennially unless the Secretary has received a complaint or has other reason to believe that the laboratory may not be in compliance with the requirements of subsection (d) or the standards issued under subsection (f).''.

SEC. 11212. MODIFICATIONS TO EXCEPTIONS FOR CERTAIN ARRANGEMENTS.

(a) EXCEPTIONS FOR BOTH OWNERSHIP AND COMPENSATION ARRANGEMENTS.—

(1) REPEAL OF EXCEPTION FOR PHYSICIANS' SERVICES.—Section 1877(b) (42 U.S.C. 1395nn(b)) is amended by striking ''Subsection (a)(1) shall not apply in the following cases:'' and all that follows through the end of paragraph (1).

(2) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by paragraph (1), is amended by inserting before paragraph (2) the following:

''(1) SHARED FACILITY SERVICES.—

"(A) IN GENERAL.—Subsection (a)(1) shall not apply in the case of a designated health service consisting of a shared facility service of a shared facility—

"(i) that is furnished—

"(I) personally by the referring physician who is a shared facility physician or personally by an individual directly employed by such a physician,

"(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

"(III) to a patient of a shared facility physician; and

"(ii) that is billed by the referring physician.

"(B) SHARED FACILITY RELATED DEFINITIONS.—

"(i) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the fa-

cility to patients of shared facility physicians.

''(ii) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

''(iii) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician who has a financial relationship under a shared facility arrangement with the facility.

''(iv) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

''(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

''(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the

arrangement, among the physicians in the arrangement, and

''(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.''.

(3) INCLUSION OF DURABLE MEDICAL EQUIPMENT AND PARENTERAL AND ENTERAL NUTRIENTS, EQUIPMENT, AND SUPPLIES IN EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by striking ''In the case of'' and all that follows through ''supplies)'' and inserting ''Subsection (a)(1) shall not apply in the case of designated health services''.

(4) NEW EXCEPTION FOR SERVICES FURNISHED IN COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—Section 1877(b) (42 U.S.C. 1395nn(b)) is amended—

(A) by redesignating paragraph (4) as paragraph (5); and

(B) by inserting after paragraph (3) the following new paragraph:

''(4) NO ALTERNATIVE PROVIDERS IN AREA.—Subsection (a)(1) shall not apply in the case of a designated health service furnished in any area with respect to which the Secretary determines that indi-

viduals residing in the area do not have reasonable access to such a designated health service.''.

(5) NEW EXCEPTION FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by paragraph (4), is amended—

(A) by redesignating paragraph (5) as paragraph (6); and

(B) by inserting after paragraph (4) the following new paragraph:

''(5) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Subsection (a)(1) shall not apply in the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(F)(i).''.

(6) NEW EXCEPTION FOR SERVICES FURNISHED IN A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by the preceding paragraphs, is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

''(6) SERVICES FURNISHED BY A HOSPICE PROGRAM.—Subsection (a)(1) shall not apply in the case

of a designated health service furnished by a hospice program under section 1861(dd)(2).''.

(7) CONFORMING AMENDMENTS.—Paragraphs (3) and (7) of section 1877(b) (42 U.S.C. 1395nn(b)), as redesignated by paragraph (6), are each amended by striking ''In the case of'' and inserting ''Subsection (a)(1) shall not apply in the case of''.

(b) REVISION OF EXCEPTIONS FOR CERTAIN COMPENSATION ARRANGEMENTS.—

(1) EXCEPTION FOR ALL ARRANGEMENTS MEETING REQUIREMENTS.—Section 1877(a)(2)(B) (42 U.S.C. 1395nn(a)(2)(B)) is amended—

(A) by striking ''except as provided in subsection (e),''; and

(B) by striking ''entity.'' and inserting ''entity which does not meet the requirements of subsection (e).''.

(2) REQUIREMENTS DESCRIBED.—Section 1877(e) (42 U.S.C. 1395nn(e)) is amended to read as follows:

''(e) REQUIREMENTS FOR PERMISSIBLE COMPENSATION ARRANGEMENTS.—The requirements under this subsection with respect to a compensation arrangement are as follows:

''(1) The arrangement is in writing and is signed by all parties to the arrangement.

''(2) The arrangement is consistent with fair market value.

''(3) The amount of compensation under the arrangement is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties. Notwithstanding the preceding sentence, nothing in this paragraph shall prohibit the payment of remuneration in the form of a productivity bonus based on services, other than designated health services, performed personally by the physician (or an immediate family member of such physician).

''(4) The arrangement would be commercially reasonable even if no referrals were made between the parties.

''(5) The items and services compensated or contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

''(6) The arrangement meets such other requirements as the Secretary may impose as needed to protect against program or patient abuse.''.

(c) REMOVAL OF HOSPITAL SERVICES FROM LIST OF DESIGNATED HEALTH SERVICES.—Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraph (K).

(d) EXPANSION OF RURAL EXCEPTION TO CERTAIN URBAN PROVIDERS.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended—

(1) by striking ''in a rural area (as defined in section 1886(d)(2)(D))'';

(2) by striking ''substantially all'' and inserting ''not less than 75 percent''; and

(3) by striking ''such a rural area'' and inserting ''a rural area (as defined in section 1886(d)(2)(D))''.

(e) PROFITS AND PRODUCTIVITY BONUSES.—Section 1877(h)(4)(B)(i) (42 U.S.C. 1395nn(h)(4)(B)(i)) is amended to read as follows:

''(i) PROFITS AND PRODUCTIVITY BONUSES.—A physician in a group practice may be paid—

''(I) a share of overall profits of the group so long as the share is not determined in any manner which is directly related to the volume or value of referrals by such physician; or

''(II) a productivity bonus based on services, other than designated health services, personally performed or incident to such personally performed services.''.

(f) EXCEPTION FOR MEDICAID MANAGED CARE ENTITIES UNDER THE MEDICAID PROHIBITION.—Section 1903(s) (42 U.S.C. 1395nn(s)) is amended by inserting after ''title XVIII'' the following: ''(unless such service was provided by an organization with a contract with a State to provide services under the State plan under this title (in accordance with subsection (m))''.

(g) EXCLUSION OF INTRAOCULAR LENS, EYEGLASSES, AND CONTACT LENSES FROM DESIGNATED HEALTH SERVICES SUBJECT TO PROHIBITIONS.—Section 1877(h)(6)(H) (42 U.S.C. 1395nn(h)(6)(H)) is amended by striking the period at the end and inserting the following: '', other than an intraocular lens inserted during or subsequent to cataract surgery, eyeglasses, or contact lenses.''.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to referrals made on or after April 1, 1996.

TITLE III—NATIONAL COMMISSION ON MEDICARE REFORM

SEC. 11301. ESTABLISHMENT OF COMMISSION.

(a) ESTABLISHMENT.—There is established a Commission to be known as the National Commission on Medicare Reform (in this title referred to as the ''Commission'').

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Commission shall be composed of 15 members of whom—

(A) five shall be appointed by the President from among officers or employees of the executive branch, private citizens of the United States, or both, of whom not more than 3 shall be of the same political party;

(B) five shall be appointed by the majority leader of the Senate from among Members of the Senate, private citizens of the United States, or both, of whom not more than 3 shall be of the same political party; and

(C) five shall be appointed by the Speaker of the House of Representatives from among Members of the House of Representatives, private citizens of the United States, or both, of

whom not more than 3 shall be of the same political party;

(2) CHAIR.—The President shall designate a Chair from among the members of the Commission.

(3) DATE.—The appointments of the members of the Commission shall be made not later than 60 days after the date of the enactment of this title.

(c) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(d) INITIAL MEETING.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting.

(e) MEETINGS.—The Commission shall meet at the call of the Chair.

(f) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

SEC. 11302. DUTIES OF THE COMMISSION.

(a) IN GENERAL.—The Commission shall—

(1) review relevant analyses of the current and long-term financial condition of the Federal Hospital

Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under title XVIII of the Social Security Act;

(2) identify problems that may threaten the long-term solvency of such trust funds;

(3) analyze potential solutions to such problems that will both assure the financial integrity of the Medicare program under such title and the provision of appropriate benefits under such program; and

(4) provide appropriate recommendations to the Secretary of Health and Human Services, the President, and the Congress.

(b) LEGISLATIVE PROPOSAL.—Not later than 1 year after all of the members of the Commission have been appointed, the Commission shall develop a legislative proposal that carries out the recommendations provided under subsection (a)(4). Such legislative proposal shall be submitted to Congress in the form of an implementing bill which contains the statutory provisions necessary or appropriate to implement the proposal. An implementing bill submitted in accordance with this subsection shall be considered by Congress under the procedures described in section 11306(b).

SEC. 11303. POWERS OF THE COMMISSION.

(a) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this title.

(b) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this title. Upon request of the Chair of the Commission, the head of such department or agency shall furnish such information to the Commission.

(c) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(d) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 11304. COMMISSION PERSONNEL MATTERS.

(a) COMPENSATION OF MEMBERS.—All members of the Commission shall serve without any additional compensation for their work on the Commission.

(b) TRAVEL EXPENSES.—The members of the Commission appointed from among private citizens of the United States shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for em-

ployees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(c) STAFF.—

(1) IN GENERAL.—The Chair of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties.

(2) COMPENSATION.—The Chair of the Commission may fix the compensation of the executive director and other personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(d) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall

be without interruption or loss of civil service status or privilege.

(e) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chair of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

SEC. 11305. TERMINATION OF THE COMMISSION.

The Commission shall terminate 30 days after the date on which the Commission submits its legislative proposal to Congress under section 11302(b).

SEC. 11306. CONGRESSIONAL CONSIDERATION OF COMMISSION PROPOSALS.

(a) IN GENERAL.—The implementing bill described in section 11302(b) shall be considered by Congress under the procedures for consideration described in subsection (b).

(b) INTRODUCTION AND REFERRAL.—

(1) IN GENERAL.—On the day on which the implementing bill described in subsection (a) is transmitted to the House of Representatives and the Senate, such bill shall be introduced (by request) in the House of Representatives by the majority leader of

the House, for himself or herself and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House and shall be introduced (by request) in the Senate by the majority leader of the Senate, for himself or herself and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate. If either House is not in session on the day on which the implementing bill is transmitted, the bill shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter on which the House is in session. The implementing bill introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(2) AMENDMENTS PROHIBITED.—No amendment to an implementing bill shall be in order in either the House of Representatives or the Senate and no motion to suspend the application of this subsection shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this subsection by unanimous consent.

(c) DISCHARGE.—If the committee to which an implementing bill described in subsection (a) is referred has not reported such implementing bill (or an identical implementing bill) by the close of the 30th day after its introduction, such committee shall be, at the end of such period, discharged from further consideration of such implementing bill, and such implementing bill shall be placed on the appropriate calendar of the House involved.

(d) CONSIDERATION.—

(1) IN GENERAL.—On or after the third day after the date on which the committee to which such an implementing bill is referred has reported, or has been discharged (under subsection (c)) from further consideration of, such an implementing bill, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the implementing bill. A Member may make the motion only on the day after the calendar day on which the Member announces to the House concerned the Member's intention to make the motion, except that, in the case of the House of Representatives, the motion may be made without such prior announcement if the motion is made by direction of the committee to which the implementing bill was re-

ferred. All points of order against the implementing bill (and against consideration of the implementing bill) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the implementing bill is agreed to, the respective House shall immediately proceed to consideration of the implementing bill without intervening motion, order, or other business, and the implementing bill shall remain the unfinished business of the respective House until disposed of.

(2) DEBATE.—Debate on the implementing bill, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 30 hours, which shall be divided equally between those favoring and those opposing the implementing bill. An amendment to the implementing bill is not in order. A motion to further limit debate is in order and not debatable. A motion to postpone, or a motion to proceed to the consideration of other busi-

ness, or a motion to recommit the implementing bill is not in order. A motion to reconsider the vote by which the implementing bill is agreed to or disagreed to is not in order.

(3) VOTE ON FINAL PASSAGE.—Immediately following the conclusion of the debate on an implementing bill described in subsection (a), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the implementing bill shall occur.

(4) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to an implementing bill described in subsection (a) shall be decided without debate.

(e) CONSIDERATION BY OTHER HOUSE.—

(1) IN GENERAL.—If, before the passage by one House of an implementing bill of that House described in subsection (a), that House receives from the other House an implementing bill described in subsection (a), then the following procedures shall apply:

(A) The implementing bill of the other House shall not be referred to a committee and may not be considered in the House receiving it except in the case of final passage as provided in subparagraph (B)(ii).

(B) With respect to an implementing bill described in subsection (a) of the House receiving the implementing bill—

(i) the procedure in that House shall be the same as if no implementing bill had been received from the other House; but

(ii) the vote on final passage shall be on the implementing bill of the other House.

(2) IMPLEMENTING BILL IN RECEIVING HOUSE.—Upon disposition of the implementing bill received from the other House, it shall no longer be in order to consider the implementing bill that originated in the receiving House.

(f) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with

respect to the procedure to be followed in that House in the case of an implementing bill described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. 11307. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to carry out the purposes of the Commission.

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